drugnet IRELAND

Issue 25
Spring 2008

Newsletter of the Alcohol and Drug Research Unit

The NDC
Directory of courses and training programmes on drug misuse in Ireland 2008
has now been published.
See details on p. 27.

Included with this issue:
Index of articles
on main topics covered in *Drugnet Ireland*, Issues 1–24

2008 – a crucial year for reviewing the impact of drugs policies

As well as Ireland's drugs strategy, the UK's drug strategy, the EU's action plan on drugs and the UN's 10-year drug-related targets are all up for review in 2008.

United Kingdom: new strategy released in February

Ahead of schedule, and following a public consultation process, the first edition of the UK's new drug strategy was released in February 2008.[1] Maintaining a single focus on illicit drugs, the new strategy places more emphasis than the previous 10-year strategy on families and communities, noting that sometimes the individual user has been the focus of too much attention at the expense of their family and the wider community. Priority will be given to providing effective treatment for those who are causing the most harm to communities and families, e.g. offenders and parents whose drug use may be putting their children at risk. Incentives to fully participate in reintegration programmes are to be strengthened. For example, the benefits system is to be re-engineered to support the new focus on reintegration, as it is not deemed 'right for the taxpayer to help sustain drug habits when individuals could be getting treatment to overcome barriers to employment'.

Ireland: new strategy by end of 2008

In January 2008 Pat Carey TD, Minister of State with responsibility for the Drugs Strategy, described the work of the new Steering Group, comprising representatives of the statutory, community and voluntary interests involved in tackling problem drug use, which was set up to oversee the development of the new strategy for the period 2009–2016.

> Over the coming months, the Group will be examining the progress and impact of the current Strategy, the degree to which it continues to be relevant and the operational effectiveness of the structures involved. They will also be looking at developments in regard to drug policies at EU and international levels. At the conclusion of the process, the Steering Group will submit recommendations to me on the shape and direction of the new Strategy.
>
> … a comprehensive public consultation process will be undertaken over the coming months as part of the work of developing the new Strategy. Indeed, I intend to be involved directly in many of the consultation meetings that are planned. I hope to be in a position to bring the new Strategy to the Cabinet Committee on Social Inclusion by the end of this year. [2]

contents

Reviewing drugs policies *(continued)*

European Union: new action plan by end of 2008

To support the implementation of the EU Drugs Strategy 2005–2012, the European Commission prepared an EU Drugs Action Plan 2005–2008. The European Commission will carry out an impact assessment in 2008 with a view to preparing the second action plan for the period 2009–2012.[3] A separate report by Niamh Randall, on page 24 of this newsletter, describes the discussion with respect to the new EU action plan at the first meeting of the EU Civil Society Forum on Drug Issues.

United Nations: new targets by mid 2009

In June 1998 the UN General Assembly met in a Special Session to address the world drug problem. The Session (referred to as UNGASS) culminated in the adoption of a Political Declaration committing some 150 states to the achievement of significant and measurable results in reduction of illicit supply and demand for drugs by the year 2008. Two other resolutions were adopted, dealing with Guiding Principles of Demand Reduction and Measures to Enhance International Cooperation to Counter the Drug Problem.

The Commission on Narcotic Drugs (CND), the central drug-policy-making body of the UN, is responsible for the review of the 1998–2008 targets. The CND has opted for a two-stage process – a review of progress in achieving the 10-year targets to be undertaken at the March 2008 CND meeting, and consideration of future directions for international drug control policy at the March 2009 meeting of the CND.[4]

This process will be supported by a series of meetings on behalf of the CND during the course of 2008/09. For example, in July 2008 NGOs involved in the drugs issue will meet in Vienna to reflect on their achievements in drug control over the past 10 years, exchange ideas on promising new approaches, reach agreements on ways to work together and make recommendations to multilateral agencies and UN member states on future directions for drug control.[5]

(Brigid Pike)

1. The consultation paper, *Drugs: Our Community, Your Say,* the report on the consultation phase*, Drugs: Our Community, Your Say. A Report on the 2007 Drug Strategy Consultation,* and the strategy*, Drugs: protecting families and communities. The 2008 Drug Strategy*, were retrieved on 1 March 2008 from http://drugs.homeoffice.gov.uk. See also Pike B (2007) Civil society calls for new directions for UK drug policy. *Drugnet Ireland*, Issue 23: 6.
2. Carey P (2008, 30 January) *Parliamentary Debates Dáil Éireann Official Report: Unrevised*. Vol. 645, No. 1, pp 413–414, PDF version. Retrieved on 7 February 2008 from www.gov.ie/oireachtas/frame.htm.
3. The EU drugs strategy and action plan were retrieved on 8 February 2008 from the website of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) http://www.emcdda.europa.eu/html.cfm/index1336EN.html. See also Pike B (2005) New EU drugs strategy to add value to National Drugs Strategy. *Drugnet Ireland*, Issue 13: 17–18; Pike B (2005) EU action plan on drugs 2005–2008. *Drugnet Ireland*, Issue 14: 3.
4. The agenda and briefing papers for the 51st Session of the CND, to be held in Vienna from 10 to 14 March 2008, were retrieved on 7 February 2008 from the website of the UN Office of Drugs Crime (UNODC) http://www.unodc.org/unodc/en/commissions/CND/session/51.html.
5. For further information, visit the website of the Vienna NGO Committee http://www.vngoc.org/detail.php?id_top=12. See also Pike B (2007) Civil society joins international debate on drug controls. *Drugnet Ireland*, Issue 22: 3.

EMCDDA evaluated

'How effective is the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)?', 'Is it achieving its tasks and goals?', 'What benefits is it providing for the European Union (EU) and its member states?' and 'Are its activities coherent with those launched by the EU institutions in the drugs field?' These were among the questions addressed in an independent evaluation of the agency, undertaken at the initiative of the European Commission, in 2007. The results of the year-long exercise were published on the EMCDDA website at the end of January 2008.[1]

According to the evaluators, the EMCDDA is 'performing well' in its core mission to provide 'factual, objective, reliable and comparable information at European level concerning drugs and drug addiction', i.e., information that is needed as an evidence base by policy makers at both national and European level. The agency's priority-setting was also found to be 'closely aligned with wider EU policy aims', such as those set in EU drugs strategies and action plans. And the EMCDDA was found to be 'almost certainly providing a more cost-effective way of monitoring the drugs situation in Europe than

EMCDDA evaluated *(continued)*

could be undertaken by the Commission itself'.

The EMCDDA's work was also judged to have had a direct impact on EU member states' drugs policies by 'encouraging a higher degree of coordination between them and the adoption of comparable structures'. The development across member states of harmonised data-collection mechanisms 'would not have taken place, at least in the same timeframe, without the EMCDDA', says the report.

The report points to various ways in which the EMCDDA's performance as information-provider on the European drug situation could be enhanced. For example, the quality of key indicator data on the drugs situation is dependent on the quality of the national data gathered, and there is still much variation in this area. At present the EMCDDA's data-collection system is 'only implemented to the extent of 60–70% at Member State level'.

The role and performance of the national focal points (NFPs), i.e. the bodies contracted in each member state to collect and submit national data as requested by the EMCDDA – the Alcohol and Drug Research Unit of the Health Research Board is the Irish NFP – is discussed. The evaluators found that, while there is generally a strong relationship between NFPs and their national authorities, the relationship between NFPs and politicians and political bodies is relatively weak. They linked this finding to the fact that the role of the EMCDDA itself is simply to provide information, rather than influence decision makers. The evaluation also revealed that NFPs enjoy generally satisfactory relationships with NGOs, professionals in the drugs field and academics, but only a third of NFPs reported that their relationship with the media 'worked well'.

(Brigid Pike)

1. For a copy of the evaluation report, see http://www.emcdda.europa.eu/about/evaluation.

Oireachtas kicks off debate on new national drugs strategy

In November 2007 Minister of State Pat Carey TD outlined his priorities for the new national drugs strategy, and invited the views of Dáil deputies. The Taoiseach and the Minister for Community, Rural and Gaeltacht Affairs were among those who contributed their throughts.[1]

An Taoiseach Bertie Ahern TD emphasised the health risks of illicit drug use and the need for individuals to take personal responsibility: 'It is not the case that one can just try them [drugs] once or twice. The physical and mental health risks are so high that an experiment need only go wrong once for serious, and sometimes fatal, consequences to arise for the drug misuser, their families, friends and members of the wider community. …They [drugs] are illegal because they are toxic; illegal drugs are a serious health risk and must remain illegal for that reason. The Government can only do so much. Individual citizens must see that there are serious physical and mental health risks attached to using illegal drugs.'

The Minister for Community, Rural and Gaeltacht Affairs, Éamonn Ó Cuív TD, reiterated the Taoiseach's emphasis on individual responsibility, but went on to argue that the use of heroin and other drugs in deprived areas was 'a slightly different issue. Many of these communities have suffered serious intergenerational problems, lack of opportunity and life expectation and isolating the drug problem from the other social issues is futile.' He described how his department had been set up to administer a range of community programmes, including RAPID, which were intended to achieve joined-up thinking in tackling the multidimensional problems, including drugs, facing such communities. He observed that social change is a slow process: a minimum of 20 years would be needed before results could be seen on the ground.

Minister Carey claimed a particular interest in two pillars of the National Drugs Strategy:

- Prevention – 'if we can prevent people starting a drug habit we can avoid the heartache and pain, as well as the expense, that arise as a result'; and
- Rehabilitation – 'if we can facilitate people to become fully involved in the process of regaining their capacity for daily life from the impact of problem drug use through a continuum of care we will, in each individual case, achieve a great deal and facilitate a better life for many'.

With regard to implementation, Minister Carey stressed the importance of inter-agency co-operation, crossing statutory, community and voluntary sectors: 'Through the new strategy, we must ensure that groups work together consistently in the coming years to maximise benefits. I ask everybody to support that as the way forward.' Flexibility and responsiveness in the face of new challenges is to be another hallmark. He described how the government had responded proactively to the emerging problem of cocaine use. In relation to the debate over the relationship between drugs and alcohol, he stated: 'I have long been of the opinion that the problems of alcohol and illicit drug use are interlinked so I will be stressing the need for synergy in the approach to these issues.'

Since last autumn Seanad Éireann has debated the drugs issue twice, including a motion that the Seanad recognise the epidemic of alcohol misuse

Oireachtas debates new strategy *(continued)*

and illegal drug use, especially cocaine, and acknowledge the need for a co-ordinated cross-departmental approach to the problem.[2] With regard to use of the term 'epidemic', Minister Carey advised that it was important to maintain perspective. Senator Ivana Bacik echoed the Minister's words of caution:

> We must be careful of our language when talking about drugs and take a rational approach. … There is certainly an epidemic of alcohol abuse … We must be careful, however, about suggesting there is a drugs epidemic, because that suggests the need for a crisis response and short-term measures. … It behoves us all to look rationally at the issue of drugs and seek credible measures to reduce the harm associated with drug abuse, and, in particular, to reduce and prevent the tragic deaths arising from drug abuse.

(Brigid Pike)

1. National Drugs Strategy: Statements (2007, 29 November) *Parliamentary Debates Dáil Éireann Official Report: Unrevised*. Vol. 642, No 5, PDF version.
2. National Drugs Strategy: Statements (2007, 17 October) *Parliamentary Debates Seanad Éireann Official Report: Unrevised*. Vol. 187, No 8, PDF version; Substance Abuse: Motion (2007, 19 December; 2008, 30 January; 2008, 6 February) *Parliamentary Debates Seanad Éireann Official Report: Unrevised*. Vol. 188, No 5, No 7, and No 9. PDF versions.
3. Bacik I (2007, 19 December) *Parliamentary Debates Seanad Éireann Official Report: Unrevised*. Vol. 188, No 5, col. 399. PDF version.

The official reports of all Parliamentary debates are available at www.gov.ie/oireachtas/frame.htm.

Evaluation of the National Drugs Awareness Campaign 2003–2005

The National Drugs Awareness Campaign was developed and launched in May 2003. The overall aim of the campaign was to 'increase awareness among the general population about current problem drug use and its consequences across society through the achievement of measurable change in the knowledge and attitude of targeted groups'.

The campaign relied heavily on multi-media components, including radio and TV advertising and a website. Live roadshows featuring question and answer sessions were staged, and booklets, posters and a helpline were developed. The campaign slogan, 'Drugs. There are answers.', was intended to convey a positive message; this approach was preferred to one that used scare tactics.

The National Advisory Committee on Drugs (NACD) commissioned a team of external researchers to review the development and delivery of the campaign from 2003 to 2005. The final report of this evaluation was published recently.[1] This article will highlight the main findings of this evaluation and will reflect on the main learning points that emerge which can be used to strengthen future campaigns.

Sampling strategy and data collection

Purposive sampling was used to select interviewees from among those actively involved in the campaign development. Those selected included members of the Steering Committee, the advertising agency, stakeholders at local and regional levels and members of the target groups. In total, 94 semi-structured interviews were conducted between November 2003 and September/October 2005 across the three phases of the campaign's development. In addition, documentary material relating to the development of the campaign was analysed.

Key findings of the evaluation

In an extensive review of the literature, the evaluation team identified certain criteria to inform best practice in developing a drugs awareness campaign. The development and implementation of the national campaign were assessed against these criteria.

Theoretical base, aims and objectives: The majority of respondents did not consider that any formal theory, model or framework had been applied to the development of the campaign. The evaluation team point out that the objectives set for the campaign, even if they were met, were incapable of achieving the stated aim of the campaign. In addition, as the campaign developed, key stakeholders reported a growing sense of confusion as to what its objectives were.

Target audiences: The interview participants did not perceive the target groups to be well defined from the start of the campaign, and felt the focus to be ad hoc rather than planned.

Multi-component media interventions: The campaign fared poorly in this area as the roadshows represented the only attempt to bolster the use of multi-media channels with a community dimension.

Message development: According to the evaluators, the theme of empowerment conveyed in the campaign slogan should have encouraged brand consciousness throughout the campaign. However, interviewees reported that they failed to recognise this and that there had been a lack of coherence to the campaign components.

Formative evaluation and process evaluation: Formative evaluation generally involves pilot-testing campaign messages, materials and lines of communication as the campaign is being formed. In this case, the development of the campaign scored highly as it used formative evaluation to assess the roadshows, the cannabis campaign and the convenience advertising. The tracking of the development of the campaign over three years by a team of external evaluators culminated in the final evaluation report presented in this article.

The findings of this evaluation suggest that this campaign suffered from a lack of coherence, because it did not have a specific theoretical framework that could have linked the various components together and given structure. Information awareness campaigns such as this one tend to

Evaluation of Awareness Campaign *(continued)*

be based on an implicit assumption that the target audience will react rationally to the messages, and take appropriate steps to avoid the consequences inherent in the behaviour being highlighted, for example, misuse of drugs. It is important that future drugs awareness campaigns learn from this evaluation, and that their development is informed by meaningful debate and reflection on the appropriate theoretical approach to take. This evaluation contains a useful review of the literature on these issues that should be used to facilitate this debate. Such a move will contribute to an evidence-based approach to what is effective in raising awareness about drugs and changing attitudes and behaviours associated with their use.

(Martin Keane)

1. Sixsmith J and Nic Gabhainn S (2007) *A process evaluation of the National Drug Awareness Campaign 2003–2005*. Dublin: National Advisory Committee on Drugs.

New Drugs Awareness Campaign launched

Ms Catherine Murphy, HSE, Minister Pat Carey, and Mairead Lyons, NACD, at the launch of the Drugs Awareness Campaign in the Mansion House (Photo courtesy DAP)

Mr Pat Carey TD, Minister of State with special responsibility for drugs strategy, launched the National Public Awareness Campaign on Drugs in the Mansion House in Dublin on 11 February. The new campaign, funded by the Health Service Executive (HSE) and the Department of Community Rural and Gaeltacht Affairs, is called 'The Party's Over' and focuses on cocaine use.

'The Party's Over' is an integrated public awareness campaign comprising several print, online and broadcasting initiatives. It includes a website (www.drugs.ie) which provides information about drugs and available services and Podcasts of discussions on drug-related topics. Visitors to site can also have live chats with experts at certain times.

Speaking at the launch, Assistant National Director, Population Health, HSE, Catherine Murphy, said: 'Experts from the areas of drugs services and health promotion have worked together to develop a campaign that will inform people about the dangers associated with cocaine use while dispelling the myths that exist around the drug.' The organisers of the campaign expressed concern at the results of a recent survey of cocaine users in which only one-third of those surveyed agreed that cocaine is a highly addictive drug, and two in five were not worried about the effect the drug might have on their health. The campaign aims to highlight the dangers of mixing alcohol and cocaine, underline the link between cocaine and crime and increase awareness of the personal and financial costs of using cocaine.

(Brian Galvin)

RDTF strategies and research

This article completes a series of articles in recent issues of *Drugnet Ireland* on the first round of strategic and action plans produced by the regional drugs task forces (RDTFs).[1] It looks at the manner in which the RDTFs address the fourth pillar of the National Drugs Strategy – Research.

The importance of research, and the resulting 'research-based evidence', is acknowledged by every RDTF. In some instances, research is identified as a strategic objective or priority, in others, as an action. The RDTFs note several shortcomings in the current provision for research activities. Drug-related research is generally conducted by national agencies (e.g. the National Advisory Committee on Drugs, the Health Research Board, Merchants Quay Ireland, the Addiction Research Centre in Trinity College, Dublin, or the Drug Treatment Centre Board), focuses on the national picture and does not provide detailed local information. Even when research is locally based, it tends to be issue-defined rather than geographically determined.

The RDTFs argue that 'well-conducted, locally-based research' is required, to ensure that resources can be allocated efficiently and effectively within RDTF areas. Calls are made for research into, variously:

- the extent and nature of the drugs situation in a region (comparable in one instance to the ESPAD survey) and the ability to monitor emerging trends;
- the needs of people living in smaller towns and rural areas, including access to services, and the needs of specific groups in a region, including homeless people, Travellers, lesbian, gay, bisexual and transgender (LGBT) people, the parasuicidal, non-Irish-nationals, young people, and children affected by problematic drug use;
- service-related options, such as the feasibility and options for introducing harm-related interventions; the feasibility of providing residential rehabilitation services for women who have young children; facilities available, particularly for young people; the optimal means of providing treatment in localities adjacent to local drugs task force areas.

As well as calling for research to support sound planning, a number of RDTFs stress the importance of evaluative research. It is viewed as a tool for 'reviewing and reflecting on practice; … informing further planning and practice; sharing and disseminating experiences, learning and good practice; being accountable …; making a case for further funding'.[2] One RDTF also emphasises the contribution that research can make to a community development approach to the drugs issue:

> This [community development] is a two way method of working and steps must be taken through the development and dissemination of sound and meaningful research within the Region to equip all stakeholders, community activists, and drug workers with accurate and up-to-date research and information. In turn, the availability of such research, and interpretations of it, will further equip parents, teachers, youth workers and young people to address drugs with a more comprehensive understanding and knowledge of their availability, outcomes, prevention techniques and projects, treatment methodology and accessibility, and support where required.[3]

The need for adequate funding for research efforts is highlighted. One RDTF observes that, in general, funding is only allocated to research if it is considered that other drug-related services are already properly funded and that this has led to situations where research activities have remained low on the agenda. Furthermore, owing to time and resource constraints, 'evaluation often becomes tacked on as "monitoring" which is frequently carried out by already stretched project staff who have limited experience in this area and very little time available to carry it out'.[4]

(Brigid Pike)

1. See Pike B (2006) RDTF strategies push out the boundaries. *Drugnet Ireland*, Issue 20: 11–12; Pike B (2007) Tools for co-ordinating drugs initiatives in the regions. *Drugnet Ireland*, Issue 21: 6–7; Pike B (2007) RDTF strategies and supply reduction. *Drugnet Ireland*, Issue 23: 4; Pike B (2007) RDTF strategies and prevention. *Drugnet Ireland*, Issue 24: 10–11. The RDTFs and treatment are considered in an article on page 7 of this issue of *Drugnet Ireland*.
2. East Coast Regional Drugs Task Force (n.d.) *Action Plan 2005–2008*, p. 96.
3. South-East Regional Drugs Task Force (February 2005) *Strategic Development Plan 2005–2008*, pp. 57–8.
4. South-West Regional Drugs Task Force (February 2005) *Strategy Document*, p. 72.

The NACD and drug research in the community and voluntary sectors

The recently published evaluation of the pilot community and voluntary sector research grants scheme funded by the National Advisory Committee on Drugs (NACD)[1] found that it had been a positive experience for all parties involved. The author recommended that the scheme should continue. However, given the relatively high cost of the scheme, she also recommended that the NACD should run the scheme in alternate years only, and that it should establish structures at a regional level to support the community organisations, funded by developing the grant scheme in partnership with the RDTFs and setting up regional research advisory groups.

1. Ennals K (2007) An evaluation of the pilot community and voluntary sector research grant scheme 2001–2005 for the National Advisory Committee on Drugs.

RDTF strategies and treatment

The regional drugs task forces (RDTFs) are responsible for co-ordinating the implementation in the regions of national drug policies, as set out in the National Drugs Strategy. Previous issues of Drugnet Ireland have looked at the overall approach taken by the RDTFs in their first strategic or action plans, and their specific responses in the areas of co-ordination, supply reduction and prevention. In this issue the responses of the RDTFs under the Treatment and Research pillars are examined.[1]

The RDTFs endorse the approach to drug-related treatment set out in the National Drugs Strategy and call for full implementation in their regions – including, for example, the continuum of care model and the use of key workers; the targeting of under-18s; the integration of prison-based and community-based treatment services; the provision of childcare facilities; and the exploration of alternative medical and non-medical treatments. The RDTF strategies also endorse the responses to emerging needs identified in the Mid-Term Review of the National Drugs Strategy, including the need to develop comprehensive rehabilitation services, and to provide support services for the parents and families of drug users as well as for drug users themselves.

Some treatment services mentioned in the national policy documents are given prominent attention in the RDTF strategies, for example, crisis support and point-of-contact services available at all times; both residential and community-based detoxification services; drop-in centres, half-way and three-quarter-way houses for respite care; and services impacting on the awareness, transmission, treatment and management of blood-borne viruses.

In relation to treatment availability and accessibility, a number of RDTFs point out that urban areas may have a critical mass of service users concentrated in the one locality, resulting in economies of scale for service provision and ease of access for users. In rural areas, however, service users may be widely scattered in small villages or remote areas, without easy access to transport. This poses logistical and social challenges in terms of providing services that are both accessible to users (either by offering transport to larger centres or by providing services locally), and also discreet (in order to minimise the risk of stigma). A number of structural adjustments are proposed, including one-stop addiction assessment and referral points; a standardised treatment infrastructure consisting of main treatment centres and satellite clinics, with particular emphasis on the network of community pharmacies and general practitioners (GPs); and greater integration of GP and community-based treatment services.

The possibilities of drug testing, not mentioned in the National Drugs Strategy, are discussed. The South-East RDTF comments, 'Those young people most at risk will be helped through increased outreach and community treatment. They could also benefit from new initiatives including drug testing, referral to innovative and increasing treatment facilities, drop-in centres, mentoring and one-to-one counselling facilities as well as awareness raising programmes'.[2] The Southern RDTF canvasses the idea that, 'With due recognition of the rights of every citizen before the Courts, urine samples should be sought from young people in this situation and evidence of illegal drugs in the system should be taken into account in deciding how best to respond to the needs of that person.'

Harm reduction principles on which the South-East RDTF predicates its drug strategy [4]

1. Accepts, for better and for worse that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than ignore or condemn them.
2. Understands drug use as a complex, multi-faceted behavioural phenomenon, ranging between severe abuse and total abstinence, and acknowledges that some ways of using drugs are safer than others.
3. Establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies.
4. Calls for the non-judgemental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
5. Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
6. Affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
7. Recognises that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
8. Does not attempt to minimise or ignore the real and tragic harm and danger associated with licit and illicit drug use.

(Brigid Pike)

1. See Pike B (2006) RDTF strategies push out the boundaries. *Drugnet Ireland*, Issue 20: 11–12; Pike B (2007) Tools for co-ordinating drugs initiatives in the regions. *Drugnet Ireland*, Issue 21: 6–7; Pike B (2007) RDTF strategies and supply reduction. *Drugnet Ireland*, Issue 23: 4; Pike B (2007) RDTF strategies and prevention. *Drugnet Ireland*, Issue 24: 10–11. The RDTFs and research is considered in an article on page 6 of this issue of *Drugnet Ireland*.
2. South-East Regional Drugs Task Force (February 2005) *Strategic Development Plan 2005–2008*, p. 56.
3. Southern Regional Drugs Task Force (February 2005) *Strategic Plan*, p. 87.
4. South-East Regional Drugs Task Force (February 2005) *Strategic Development Plan 2005–2008*, pp. 56–7.

Drugs task force expenditures

In a recent written answer to a Parliamentary Question, Pat Carey TD, Minister of State with special responsibility for the Drugs Strategy, outlined the number, size and scale of the ten regional drugs task forces (RDTFs) (see Table 1).[1] Minister Carey explained that expenditure by the RDTFs is building up. In 2007 alone it was expected to exceed €7 million, and when the RDTFs are fully operational, expenditure will be in the region of €14 million per annum. The RDTFs may also seek capital funding under the Premises Initiative and approximately €0.8 million was allocated for this in 2007.

In a separate written answer on the 12 local drugs task forces (LDTFs) in Dublin (excluding Bray and Cork), Minister Carey reported their current and capital expenditures, and allocations under the Young People's Facilities and Services Fund, for 2005 and 2006 (see Table 2).[2]

(Brigid Pike)

1. Carey P (2007, 1 November) *Parliamentary Debates Dáil Éireann Official Report: Unrevised*. Vol. 640, cols 1619–21, PDF. Available at www.gov.ie/oireachtas/frame.htm.
2. Carey P (2007, 1 November) *Parliamentary Debates Dáil Éireann Official Report: Unrevised*. Vol. 640, cols 1676–78, PDF. Available at www.gov.ie/oireachtas/frame.htm.

Table 1 RDTFs – catchment areas, current expenditure 2004–2006, approximate population, number of persons whose employment is funded by RDTFs

Regional drugs task force		Catchment area	Expenditure 2004–2006 (€m)	Approximate population	Number employed by RDTF (incl. project workers)
ECRDTF	East Coast	Dún Laoghaire/Rathdown and East Wicklow	0.468	188,231 (excl. Bray and Dún Laoghaire)	16 (13 project workers)
MRDTF	Midland	Counties Laois, Longford, Offaly, Westmeath	0.210	251,664	4 (1 project worker)
MWRDTF	Mid-Western	Counties Clare, Limerick, North Tipperary	0.437	361,028	7 (4 project workers)
NDRDTF	North Dublin	North Dublin City and Fingal	0.390	239,992 (Fingal only)	10 (8 project workers)
NERDTF	North East	Counties East Cavan, Louth, Meath, Monaghan	0.671	362,096	21 (18 project workers)
NWRDTF	North West	Counties Donegal, Leitrim, Sligo and West Cavan	0.241	269,109	7 (5 project workers)
SRDTF	Southern	Counties Cork, Kerry (excl. Cork City)	0.398	501,754	23 (22 project workers)
SWRDTF	South West	South Dublin City, South Dublin, County Kildare and West Wicklow	0.455	433,270 (Kildare and South Dublin)	8 (5 project workers)
SERDTF	South East	Counties Carlow, Kilkenny, South Tipperary, Waterford, Wexford	1.437	460,838	26 (26 project workers)
WRDTF	Western	Counties Galway, Mayo, Roscommon	0.501	414,277	12 (10 project workers)
TOTAL			**5.208**	**3,482,259**	**134 (112 project workers)**

Table 2 Dublin LDTFs – current and capital expenditure, and YPFSF funding, 2005 and 2006

Year	LDTF Process (€m)	Emerging Needs Fund (€m)	Premises Initiative Fund (€m)	Young People's Facilities and Services Fund (€m)
2005	13.086	0.013	0.452	10.9
2006	12.965	1.803	1.262	10.2

Drug misuse and the family discussed at BIC meeting

Following its tenth Summit meeting, held in Dublin on 14 Februry 2008, the British-Irish Council (BIC) issued a communiqué regarding drug misuse and the family:

> Misuse of drugs can have a devastating effect on the family. The Heads of Administrations discussed the importance of supporting families to overcome the problems they face and the role families can play in the rehabilitation process.
>
> They reflected on the impacts of problem drug use on families and how these could be used in administrations' development of their drugs and/or alcohol strategies. They discussed the need to further develop advice and guidance for families, and to improve support to families in dealing with drugs treatment and rehabilitation processes. They recognised the importance of strategies to reduce the potential harm to the children of problem drug users. The Council also considered ways to utilise the potential of families as agents for drug use recovery.
>
> The Council agreed to include a renewed focus on the families of problem drug users in any future drugs strategies prepared, with a view to providing increased support to those families and to better harness their potential to facilitate life improvements for problem drug users.

For further information on the British–Irish Council and its work in the drug policy domain, visit www.british-irishcouncil.org.

(Brigid Pike)

HSE outlines plans for drug and alcohol services in 2008

The HSE's National Service Plan 2008 (NSP) outlines the agency's plans in the drugs and alcohol area during 2008.[1] The HSE's Addiction Services, including both illicit drugs and alcohol, are delivered through Social Inclusion Services, which is part of the Primary, Community and Continuing Care (PCCC) directorate. Table 1 overleaf summarises the deliverables identified for 2008 in respect of illicit drugs and alcohol, together with the outputs achieved in 2007.

The performance targets for Addiction Services in 2008 have been set as follows:

- Percentage of substance misusers for whom treatment commenced within one month is to exceed the 84% level achieved in 2007.
- The average number of clients in methadone treatment per month is to reach 7,000, the same level as in 2007.

No target has been set for a third performance measure – the number of substance misusers under 18 years for whom treatment is commenced. The NSP explains, 'Additional staff to support key service developments for under-18 services with addiction has been identified for 2008. The impact of these appointments on current levels of service provision will be monitored through our service plan reporting.'

The focus of the Population Health Directorate of the HSE in 2008 will include, among other things, further developing, in conjunction with the departments of Education and Health, the delivery of the Social Personal and Health Education (SPHE) programme; further research and education initiatives on alcohol in pregnancy; starting a health impact assessment project on alcohol off-sales; and continuing to work with the Department of Health on matters such as alcohol advertising and off-sales.

The establishment of a unified health system is seen as an opportunity to establish new structures and mechanisms to promote the reduction of health inequalities. The HSE is extending social inclusion from its traditional focus on the care and support needs of vulnerable groups such as drug users, to enhancing the responsiveness of all services at all levels of care and thus improving access to health services for all service users. Initiatives include:

- A new contractual framework for the GMS and other publicly-funded services involving GPs has been developed. One objective is to achieve greater responsiveness to the needs of vulnerable patients such as the homeless or those with addiction problems. In 2008 this new framework will be signed off on by HSE management, and engagement with key stakeholders will commence.
- A review was completed in 2007 of the current arrangements for the management of health and personal social services provided by the non-statutory sector, in recognition of the need to develop standardised processes that safeguard service users, ensure transparency and fairness in the awarding of funding, link payments to service levels and outcomes, and use formal service level agreements. A new management framework was adopted and during 2008 this new approach will be implemented in the HSE.

(Brigid Pike)

1. Health Service Executive (2007) *National Service Plan 2008*. Available at www.hse.ie

HSE outlines plans *(continued)*

Table 1 Addiction Services in 2008 (after *HSE NSP* 2008: 51–52)

Focus	Outputs 2007	Deliverables 2008
National Drugs Strategy The National Drugs Strategy comes to an end in 2008 and is being reviewed. The Department of Community, Rural and Gaeltacht Affairs is currently establishing a structure for this review. The HSE will have a critical role to play in this.		Participate in review of the National Drugs Strategy.
Cocaine treatment	National co-ordinator employed to lead the National Addiction Training Programme, with initial emphasis on cocaine training.	Implementation of the National Addiction Training Programme progressed.
Development of treatment services for under-18s	Primary notification in place for multidisciplinary team enhancement and developments.	Development of multidisciplinary team enhancements and related services.
Data collection The provision of robust information to underpin service planning in drug and alcohol services is a priority for Social Inclusion services.	Glossary agreed with the Health Research Board (HRB). Mapping completed and gaps identified in data-collection systems from treatment services.	Examination and reconfiguration of performance indicators for drug and alcohol. Mapping of data collection systems.
Health Atlas The Health Atlas aims to enable web-based mapping of health related data on a national basis.	Mapping services completed and framing of 4-tier model progressed to Health Atlas.	Drug and alcohol information input to Health Atlas.
Quality initiatives / standards Quality in alcohol and drug services (QUADS) and Drug and Alcohol Occupational Standards (DANOS) are benchmarking standards for the drug and alcohol service.	QUADS / DANOS accepted as the benchmarking standards.	Use of QUADS mapped around the country. Ramifications for implementing DANOS explored.
Drugs task force mainstreaming The Department of Community, Rural and Gaeltacht Affairs has funded a number of drugs task force pilot projects.	Working group established to plan mainstreaming of drugs task force projects. Mainstreaming proposal document developed. Review under way of the list of projects to ensure they are in line with HSE policy.	Process agreed with DCRGA and DOHC to manage mainstreaming of the National Drugs Strategy projects that have been evaluated. Project-by-project analysis of drugs task forces undertaken. Projects mainstreamed.
Links to HSE Working Group on Alcohol	Cross-directorate process established with Office of the CEO, Primary, Community and Continuing Care, and National Hospitals Office.	Cross-directorate strategic focus on alcohol developed. Best-practice guidelines for the alcohol services developed.
National Drugs Rehabilitation Strategy Rehabilitation is a key priority in 2008.	National Drugs Strategy report on rehabilitation completed.	Drug Rehabilitation Implementation Committee developed.

Trends in treated problem alcohol use, 2004–2006

On 18 March 2008, the Health Research Board published preliminary trends in treated problem alcohol use based on data reported to the National Drug Treatment Reporting System (NDTRS).[1] A total of 16,020 cases were treated for problem alcohol use in Ireland between 2004 and 2006. It is important to note that the reporting system collects data on episodes of treatment, rather that the number of individual people treated each year. This means that individuals may appear more than once if they attend more than one treatment service in a year, and may reappear in subsequent years.

Of the cases treated for problem alcohol use between 2004 and 2006, 59% entered treatment for the first time. There was a 21% increase in the number of new cases during the reporting period. The increase in numbers could be explained by an increase in problematic alcohol use in the population, an increase in the number of service providers reporting treated cases to the NDTRS, or a combination of these two factors.

Between 5,000 and 5,500 cases were treated each year and reported to the monitoring system. It is essential to point out that the collection of treatment figures for alcohol is still in the initial stages and that not all alcohol treatment services provided information for the three-year period under review. This means that the figures presented are an underestimate of the true extent of treated alcohol use in Ireland and reflect the degree of participation in the reporting system by treatment services, rather than the actual levels of treatment required or, indeed, provided in any one region. For example, participation by services in the East (Wicklow, Kildare and Dublin) and the West (Galway, Mayo and Roscommon) is still incomplete.

Of note, one in five new cases treated for alcohol as a main problem substance reported a problem with one or more other drugs. Cannabis (16%), cocaine (7%), ecstasy (7%) and amphetamines (2%) were the four most common additional problem drugs reported. The number of new cases receiving treatment for problem use of both alcohol and cocaine increased by 40% in the three-year period, although the overall number of such cases is still low. Research has shown that the use of these two drugs together results in the formation of cocaethylene, which potentiate the cardiotoxic effects of cocaine alone. Taking cocaine and alcohol together can also increase the likelihood of violent thoughts, which can in turn lead to violent behaviour.

Of the alcohol cases treated for the first time, 68% were men; one-third were unemployed; and 2.5% were homeless. New cases treated for problem alcohol use combined with one or more other problem drugs were more likely to be men, under 18 years of age, homeless and unemployed than those treated for problem alcohol use only.

In line with the growing number of people of other nationalities living in Ireland, there was an increase in the number of non-nationals treated for problem alcohol use during the reporting period.

The NDTRS records the treatment intervention(s) provided when the client is first admitted to a treatment service. Counselling was the most common initial treatment intervention in 2006 and was recorded for over three-quarters (77%) of all treated cases. This was followed by alcohol detoxification, which was provided to 28% of cases, and education awareness programmes provided to 25% of cases. Approximately one in five treated cases received medication-free therapy (23%), family therapy (21%) or brief intervention (20%).

(Jean Long)

1. Fanagan S, Reynolds S, Mongan D and Long J (2008) *Trends in treated problem alcohol use in Ireland, 2004 to 2006*. Trends Series 1. Dublin: HRB. Available at www.hrb.ie.

Alcohol consumption patterns 1992–2002

Eurobarometer 37.01[1] was conducted in 1992 and contained questions about alcohol use. The basic sample design applied to all member states was a multi-stage, random one. All interviews were conducted face-to-face in people's homes. The National Health and Lifestyle Survey (SLAN) was first undertaken in 1998[2] by the National University of Ireland, Galway, and repeated again in the summer of 2002.[3] In both rounds, a representative cross-section of the Irish adult population was surveyed by post, with a section of each survey devoted to alcohol use. On both occasions a national sample was generated randomly from the Irish electoral register.

Eurobarometer (1992) had 1,877 valid respondents aged 18 years or over, SLAN (1998) had 6,370 and SLAN (2002) had 5,931. Respondents' average alcohol intake was measured in units of alcohol typically imbibed in one week. One unit of alcohol was calculated as a half pint of beer, lager, stout or cider, a single measure of spirits or a single glass of wine, sherry, port or premixed drinks. Abstainers represented 39% of the overall sample population in 1992, 17% in 1998 and 16% in 2002. The abstainers in 1992 were 48% women (454) and 30% men (274); in 1998, 19% women (622) and 14% men (400); and in 2002, 17% women (581) and 15% men (349).

Respondents who consumed at least one unit of alcohol a week represented 61.2% (1,149) of the sample population in 1992, 53.7% (3,418) in 1998 and 48.6% (2,885) in 2002, and are therefore well represented for the purpose of secondary analysis.

Table 1 details the average number of units, by type of alcohol, consumed per week by respondents in the three survey periods. The mean range of values is used to report average consumption, as different methods were employed to collect data for Eurobarometer and for SLAN. A statistically significant increase or decrease in consumption can be said to occur if no overlap exists between the mean ranges reported for consecutive survey years.

In all three survey years, respondents who drank beer had the highest weekly alcohol intake, while wine drinkers reported the lowest levels. The increase in weekly consumption between 1992 and 1998 is significant for every alcohol type, with beer drinkers showing the greatest increase, imbibing 9.0–9.6 units of alcohol more per week in 1998 than in 1992. Wine drinkers showed the second highest increase in average weekly consumption over this period, at 5.8–6.3 units. Consumers of spirits showed the smallest increase, at 4.3–4.8 units.

It must be noted that there are limits to the extent to which the Eurobarometer and SLAN data typify the level of alcohol use in Ireland. Neither survey was designed to collect information specifically on alcohol use, and results may have been influenced by methodological differences, such as sampling frame, item wording, and method and timing of data collection. The Eurobarometer survey reported a much higher response rate than either of the SLAN surveys, possibly because it was administered through face-to-face interviews rather than by post. Nevertheless, both surveys offer some insights into trends in alcohol consumption in Ireland from 1992 to 2002.

(Aileen Connor)

1. Eurobarometer 37.01 merges the responses to identical questions from two Eurobarometer surveys, *Eurobarometer 37.0: Awareness and importance of Maastricht and the future of the European Community*, March-April 1992 and *Eurobarometer 37.1: Consumer goods and social security,* April-May 1992. Brussels: INRA (Europe). Available at http://www.ucd.ie/issda
2. SLAN (1999) *The National Health and Lifestyle Surveys*. Centre for Health Promotion Studies, NUI, Galway and Department of Health and Children.
3. SLAN (2003) *The National Health and Lifestyle Surveys*. Centre for Health Promotion Studies, NUI, Galway and Department of Health and Children.

Table 1 Current drinkers' alcohol consumption pattern and average units consumed weekly, by type of alcohol

	Eurobarometer 1992		SLAN 1998		SLAN 2002	
Alcohol type	Number (%) of current drinkers	Average units per person per week	Number (%) of current drinkers	Average units per person per week	Number (%) of current drinkers	Average units per person per week
All	1149	7.0–7.3	3418	13.9–14.4	2885	13.3–13.7
Beer	898 (78.2%)	7.5–7.8	2488 (73%)	16.6–17.4	1659 (58%)	16.1–17.0
Spirits	528 (46.0%)	6.9–7.4	769 (23%)	11.2–12.1	706 (25%)	11.9–12.8
Wine	231 (20.1%)	4.8–5.3	1009 (30%)	10.7–11.5	1233 (43%)	10.8–11.5

Initiatives on alcohol

Advisory group to examine laws on sale of alcohol

On 9 January, the Minister for Justice, Equality and Law Reform, Mr Brian Lenihan TD, announced that the Government had approved his proposal to set up an advisory group to examine key aspects of the law governing the sale and consumption of alcohol. The group, to be chaired by Dr Gordon Holmes, will report to the Minister by 31 March 2008, enabling legislation to be enacted before the summer recess.

The group has been established against a background of a 17% increase in alcohol consumption in the past decade. In addition, there has been a 35% increase in the number of off-licenses between 2003 and 2005 (up from 785 to 1,070) and an increase of 20% in the number of premises with wine-only licences.

The issues to be examined by the group are:

- The increase in the number of supermarkets, convenience stores and petrol stations with off-licences and the manner and conditions of sale of alcohol products in such outlets, including below-cost selling and special promotions;
- The increasing number of special exemption orders which permit longer opening hours being granted to licensed premises around the country; and
- The use, adequacy and effectiveness of existing sanctions and penalties, particularly those directed towards combating excessive and underage consumption.
- Minister Lenihan stated that, in parallel with this initiative, work would continue on drafting the Sale of Alcohol Bill, which is included in the government's legislation programme for 2008. This Bill will modernise and streamline the laws relating to the sale and consumption of alcohol.

Alcohol to carry health labels

Drinks Manufacturers of Ireland (DMI), the representative body for the alcohol beverage manufacturing sector, has reached agreement with government and the other social partners to introduce a mandatory system of labelling on alcoholic drinks sold in Ireland.

The industry has agreed to introduce labels that will specify the amount of alcohol in a product, and will include guidelines for sensible drinking. The labelling will also feature information advising women on the dangers of drinking alcohol while pregnant. It is hoped that the labels will convince pregnant women that it is in the best interests of their unborn child not to consume any amount of alcohol while pregnant. The aim of the health warnings is to 'caution women of the dangers of consuming alcohol while pregnant' and to create a more health conscious society where consumers 'keep within sensible guidelines' and make 'informed choices about their alcohol consumption'. The government will now have to draft the necessary legislation to give effect to the agreed changes.

Drink driving limit to remain unchanged for at least another 18 months

The Road Safety Strategy 2007–2012 published in October 2007 recommends lowering the drink-drive limit by June 2009, but does not suggest what that limit should be. According to Minister for Transport Noel Dempsey, an advisory panel will make recommendations on a reduced blood alcohol concentration (BAC) limit early in 2008, and the new limit should be in place ahead of the deadline of June 2009 contained in the Strategy.

Ireland and the UK have a BAC limit for drivers of 80mg/100ml, while all other European countries have moved to a 50mg/100ml limit. Alcohol is estimated to be a contributory factor in 37% of all fatal crashes in Ireland, and 90% of the drivers involved in these cases were male. Alcohol is a factor in half of all fatal crashes involving males aged under 35 years. Speaking at the launch of the Strategy, Mr Dempsey stated that he, personally, was in favour of a move from the current level of 80mg/100ml to 50mg/100ml.

(Deirdre Mongan)

Review of policy on alcohol pricing in Scotland

In December 2007 Scottish Health Action on Alcohol Problems (SHAAP) published the findings of an expert workshop convened in September 2007 to consider possible government action on pricing policy to reduce alcohol-related harm in the population.[1]

Alcohol-related morbidity and mortality are increasing in the UK. Between 1991 and 2004 the number of alcohol-related deaths almost doubled. Over the past 30 years, liver cirrhosis mortality has risen by over 450% across the population, as well as peaking at a younger age. In Scotland, there was a 52% increase in alcoholic liver disease between 1998 and 2002. According to the Scottish Health Survey in 2003, 27% of men and 14% of women reported drinking more than the recommended weekly limits. Alcohol-related problems are estimated to cost Scotland over one billion pounds every year.

Review of alcohol pricing *(continued)*

In the past 40 years, alcohol consumption in the UK has doubled, rising from 5.7 litres of pure alcohol per person aged 16 or over in 1960 to 11.3 litres in 2005. Another significant change in recent years is the shift away from drinking outside the home to drinking at home. Sales by the off-trade sector now account for nearly half of all the alcohol sold in the UK.

Alcohol is price sensitive, and research shows that an increase in price will lead to a decrease in consumption, and vice versa. Even though the sale price has increased, the real price of alcohol has been in steady decline. Because households' disposable income had increased by 97% in real terms, alcohol was 62% more affordable in 2005 than in 1980. Competition between sellers of alcohol has also driven down prices. In 2007, 10 grocery retailers, including Tesco, Aldi and Lidl, reported to an inquiry by the UK Competition Commission that they sold alcohol below cost, and used temporary promotions as a means of attracting customers into the store and increasing total sales. Supermarkets accounted for more than 60% of the volume of alcohol sold in the off-trade market in 2006.

Alcohol policy has tended to focus on the minority of the drinking population who are the heaviest drinkers. In reality, it is the much greater number of drinkers in a population who drink to excess on occasion that accounts for most of the alcohol-related problems. A Finnish study revealed that the majority of problems were found in the 90% of the population who were moderate consumers, rather than in the 10% who drank heavily.[2]

The World Health Organization has stated that the most effective alcohol policies include alcohol-control measures (price and availability), drink-driving laws, and brief interventions for hazardous and harmful drinkers. In the UK, by contrast, strategies aimed at reducing escalating levels of alcohol-related harm have focused predominantly on specific groups of 'problem' drinkers, identified as under-18s and young 'binge drinkers'. A strategy which targets only these groups, without addressing the wider drinking culture and environment, ignores the fact that young people do not form their views and attitudes towards alcohol use in isolation, but are influenced by their parents' drinking habits and the culture of drinking in their own area. The UK strategies also rely heavily on policies with the weakest evidence base – education and voluntary regulation by the alcohol industry – in attempting to effect change. They are further undermined by action taken by government to relax controls on the supply of alcohol. Alcohol is now available in more places, for longer periods, and at more affordable prices.

A lot of emphasis in UK alcohol strategies is placed on individual responsibility for appropriate drinking behaviour, with some commentators arguing that alcohol consumption is entirely a matter of individual responsibility, not an area to be regulated by government intervention. Harmful alcohol use is rarely, if ever an 'individual' problem; it impacts on family, friends, work colleagues, and ultimately society as a whole.

The SHAAP report advocates using price as a lever to reduce alcohol consumption and related harm. Based on estimates by the Academy of Medical Sciences, a 10% rise in alcohol price would save the lives of 479 men and 265 women in Scotland each year. The report recommends that the Scottish government:

- Ends irresponsible alcohol promotions in all licensed premises
- Establishes minimum prices for alcoholic drinks
- Makes representation to Westminster (a) to increase alcohol duty and link alcohol taxes to inflation, and (b) to link levels of taxation to alcohol strength
- Reconvenes the National Licensing Forum with appropriate health representation
- Considers whether there is a need to create an independent, regulatory body to protect the health of the nation in relation to alcohol
- Considers jointly initiating a Parliamentary inquiry into the health and social harm caused by alcohol in Scotland.

While this report concentrates on Scotland, many of the issues addressed are relevant to the current situation in Ireland, where the rise in alcohol consumption in the past decade has coincided with an increase in alcohol-related morbidity and mortality. There has been a shift from drinking in licensed premises to drinking at home, and the real price of alcohol has fallen, particularly in the off-trade sector. In its efforts to reduce alcohol-related harm in Ireland, the government should consider introducing policy measures similar to those recommended in this report.

(Deirdre Mongan)

1. Gillan E and Macnaughton P (2007) *Alcohol: price, policy and public health*. Edinburgh: Scottish Health Action on Alcohol Problems (SHAAP).
2. Poikolainen K, Paljärvi T and Makela P (2007) Alcohol and the preventive paradox: serious harms and drinking patterns. *Addiction*, 102: 571–578.

Keltoi completes an outcome study

Minister of State Pat Carey TD launched a client evaluation study of the Keltoi treatment centre in Dublin on 12 November 2007.[1] Funded by the Health Service Executive, the study was a cross-sectional survey of a sample of clients who had been discharged between one and three years prior to interview.

The treatment model employed by Keltoi is unique in Ireland. It is based on international findings that rehabilitation with a focus on developing new living skills produces more favourable outcomes. According to Keltoi, a favourable outcome sees clients developing and successfully maintaining a drug-free lifestyle.

Of the 485 clients referred to Keltoi between 2002 and 2004, 149 (31%) were treated. Ninety-five per cent of clients admitted to the treatment programme had severe opiate dependence problems, and a small proportion had severe cocaine dependence. To be admitted to the programme, clients had to be drug-free for two to six weeks, depending

on the individual case and the assessment of the team. Ninety-two participants (62%) agreed to be interviewed, two of whom died prior to the interview date. Eighty questionnaires were completed. The final sample comprised 52 (74%) men, 18 (26%) women and 10 individuals whose gender was not recorded.

The study reported that a large proportion of those who started treatment completed it (83%, 58/70). Half (29/58) of those who completed treatment were drug free in the month prior to the interview. The abstinence rate for men (50%) was higher than that for women (39%). The proportion who committed at least one crime during the 30 days prior to interview was lower among those who had not used drugs in that time than among those who had, 15% compared to 30%. Five of the 29 who had used at least one drug in the last month had injected it.

Although not directly comparable, these study findings follow the same trend as those of the ROSIE study,[2] which indicated that opiate treatment in residential facilities is reasonably successful. The limitations of this study are that there are no baseline data and drug-free status is self-reported. In addition, it is possible that other treatment interventions may have taken place between discharge from Keltoi and the study interview and these may account for some of the positive findings. Nevertheless, these findings indicate that the Keltoi approach to treatment for drug users can lead to favourable outcomes.

(Vivion McGuire and Jean Long)

1. Sweeney B, Browne C, McKiernan B and White E (2007) *Keltoi client evaluation study*. Dublin: Health Service Executive.
2. Cox G, Comiskey C and Kelly P (2007) *ROSIE Findings 3: Summary of 1-year outcomes. Abstinence modality*. Dublin: National Advisory Committee on Drugs.

Dr Brion Sweeney, one of the authors of the Keltoi evaluation, speaking at the launch of the report (Photo: JJ Berkeley)

Mr Noel Mulvihill, HSE, at the Keltoi launch (Photo: JJ Berkeley)

Drug use in the general population, 2006/7: repeat survey

On 25 January 2008, the National Advisory Committee on Drugs (NACD) and the Department of Health, Social Services and Public Safety (Northern Ireland) published jointly the second all-Ireland general population drug prevalence survey.[1] Minister of State with responsibility for drugs strategy, Pat Carey TD, launched the findings for Ireland.

Drug prevalence surveys of the general population are important in that they can shed light on the patterns of drug use, both demographically and geographically and, when repeated, can track changes over time. They help to increase our understanding of drug use, and to formulate and evaluate drug policies. They also enable informed international comparisons provided countries conduct surveys in a comparable manner.

The Irish survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The questionnaire, based on the 'European Model Questionnaire', was administered in face-to-face interviews with respondents aged between 15 and 64 years normally resident in households in Ireland and Northern Ireland. With the exception of two questions and two show cards, the questionnaire employed for the 2006/7 survey was the same as that used in 2002/3.[2] Fieldwork was carried out by MORI MRC during late 2006 and early 2007. The final achieved sample was 4,967 in Ireland. This represented a response rate of 65%. The sample was weighted by gender, age and region to ensure that it was representative of the general population.

The proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime increased by five percentage points, from 19% in 2002/3 to 24% in 2006/7 (Table 1). The proportion of young adults (aged 15–34 years) who reported using an illegal drug in their lifetime also increased by five percentage points, from 26% in 2002/3 to 31% in 2006/7. As expected, more men reported using an illegal drug in their lifetime than women.

The proportion of adults who reported using an illegal drug in the last year increased marginally, from 6% in 2002/3 to 7% in 2006/7 (Table 1). The proportion of young adults who reported using an

Drug use in the general population *(continued)*

Table 1 Lifetime, last-year and last-month prevalence of illegal drug use in Ireland, 2002/3 and 2006/7

Illegal drug use*	Adults 15–64 years %		Males 15–64 years %		Females 15–64 years %		Young adults 15–34 years %	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	18.5	24.0	24.0	29.4	13.1	18.5	26.0	31.4
Last year	5.6	7.2	7.8	9.6	3.4	4.7	9.7	12.1
Last month	3.0	2.9	4.1	4.3	1.7	1.4	5.2	4.8

* Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008)

Table 2 Lifetime, last-year and last-month prevalence of cannabis use in Ireland, 2002/3 and 2006/7

Cannabis use	Adults 15–64 years %		Males 15–64 years %		Females 15–64 years %		Young adults 15–34 years %	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	17.4	21.9	22.4	27.0	12.3	16.6	24.0	28.6
Last year	5.0	6.3	7.2	8.5	2.9	3.9	8.6	10.4
Last month	2.6	2.6	3.4	4.0	1.7	1.1	4.3	4.2

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008)

illegal drug in the last year increased from 10% in 2002/3 to 12% in 2006/7. The proportion of adults who reported using an illegal drug in the last month remained stable.

Cannabis was the most commonly used illegal drug in Ireland. The proportion of adults who reported using cannabis at some point in their life increased from 17% in 2002/3 to 22% in 2006/7 (Table 2). Proportions using cannabis reflect the same pattern as the proportions using any illegal drug described above.

Nine per cent of young adults claimed to have tried ecstasy at least once in their lifetime in 2006/7 (Table 3).

Cocaine use increased in 2006/7 compared to 2002/3. The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 3% in 2002/3 to 5% in 2006/7 (Table 4). The proportion of young adults who reported using cocaine in their lifetime also increased, from 5% in 2002/3 to 8% in 2006/7. As expected, more men reported using cocaine in their lifetime than women.

The proportion of adults who reported using cocaine in the last year increased from 1% in 2002/3 to 2% in 2006/7 (Table 4). The proportion of young adults who reported using cocaine in the last year increased from 2% in 2002/3 to 3% in 2006/7. The proportion of adults who reported using cocaine in the last month remained stable at under 1%.

There was a considerable increase in the proportions using any illegal drug at some point in their lives. This is influenced by the fact that drug use in Ireland is a recent phenomenon and that the population of lifetime and recent drug users in Ireland is relatively young. Drug use is measured among adults aged 15–65, and those leaving this age group over the next fifteen to twenty years are less likely to have been exposed to drug use than those entering the measurement cohort.

Table 3 Lifetime, last-year and last-month prevalence of ecstasy use in Ireland, 2002/2003

Ecstasy use	Adults 15–64 years %		Males 15–64 years %		Females 15–64 years %		Young adults 15–34 years %	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	3.7	5.4	4.9	7.2	2.6	3.6	7.1	9.0
Last year	1.1	1.2	1.7	1.8	0.5	0.6	2.0	2.4
Last month	0.3	0.3	0.7	0.5	0.0	0.2	0.6	0.6

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008)

Table 4 Lifetime, last-year and last-month prevalence of cocaine use (including crack) in Ireland, 2002/2003

Cocaine use	Adults 15–64 years %		Males 15–64 years %		Females 15–64 years %		Young adults 15–34 years %	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	3.0	5.3	4.3	7.0	1.6	3.5	4.7	8.2
Last year	1.1	1.7	1.7	2.3	0.5	1.0	2.0	3.1
Last month	0.3	0.5	0.7	0.8	0.0	0.2	0.7	1.0

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008)

Drug use in the general population *(continued)*

Survey data on drug use in the last year shows an increase in the proportions using cannabis and, to a lesser extent, cocaine. These results follow trends observed in treatment data. At the launch of this report, Minister Carey said: 'While cannabis continues to be the most commonly used illegal drug, cocaine use has grown, particularly among the young adult population. This finding is in line with [the findings of a joint NACD/NDST] report on cocaine which was published last year, with the experiences of those working in the field and with expectations generally.'

When compared to the 19 countries that completed a general population survey on drug use, Ireland ranks seventh for lifetime use of cannabis, fourth for lifetime use of amphetamines, fourth for use of cocaine, third for ecstasy and third for LSD.

(Jean Long)

1. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2008) *Drug use in Ireland and Northern Ireland: first results from the 2006/2007 drug prevalence survey*. Dublin: National Advisory Committee on Drugs.
2. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005) *Drug use in Ireland and Northern Ireland: first results (revised) from the 2002/2003 drug prevalence survey*. Dublin: National Advisory Committee on Drugs.

Trends in alcohol and drug admissions to psychiatric facilities

The annual report *Activities of Irish psychiatric units and hospitals 2006*, published by the Mental Health Research Unit of the Health Research Board in December 2007, shows that the total number of admissions to inpatient care has continued to fall.[1]

In 2006, 2,767 cases were admitted to psychiatric facilities with an **alcohol disorder**, of whom 851 were treated for the first time.[1] Figure 1 presents the rates of first admission between 1990 and 2006 of cases with a diagnosis of alcohol disorder, per 100,000 of the population.[1-5] It is notable that the rate decreased steadily between 1991 and 2004 and more than halved during the reporting period. The rate stabilised in 2004 and 2005, but decreased again in 2006. The trend since the early nineties reflects changes in alcohol treatment policy and practice, and the resultant increase in community-based and special residential alcohol treatment services. Of the 2,733 discharges with an alcohol disorder, just under 41% spent less than one week in hospital and 19% spent more than one month in hospital. Whether or not these admissions were appropriate, and in line with the recommendations of the mental health policy, *A vision for change*, could not be discerned from the report as the numbers with co-morbid illness were not reported.

In 2006, 663 cases were admitted to psychiatric facilities with a **drug disorder**, of whom 250 were treated for the first time.[1] The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 2 presents the rates of first admission between 1990 and 2006 of cases with a diagnosis of drug disorder, per 100,000 of the population.[1-5] The rate increased steadily between 1990 and 1995, with a dip in 1996, and further annual increases between 1997 and 2001. The rate was almost three times higher in 2001 than it was in 1990. Notable dips in the rate occur in the census years 1996 and 2002, and

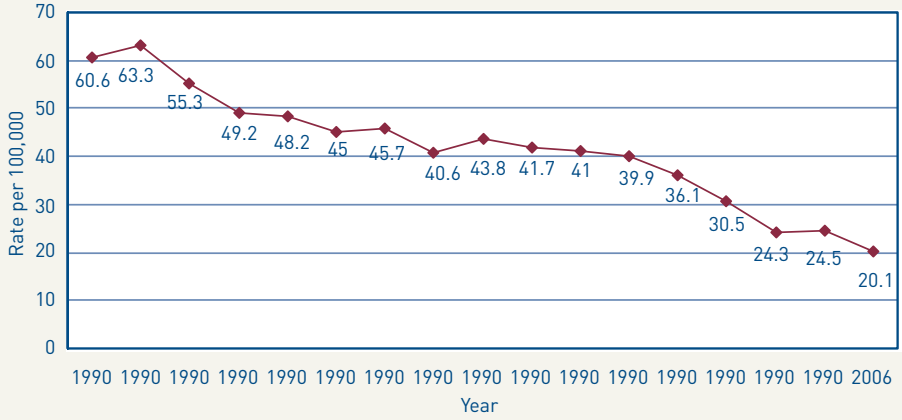

Figure 1 **Rates of psychiatric first admission of cases with a diagnosis of alcohol disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the National Psychiatric Inpatient Reporting System, 1990 to 2006**

Trends in psychiatric admissions *(continued)*

can be partly explained by the increased population figure used as the denominator in calculating the rate for those years. The overall increase in the rate of drug-related first admissions between 1990 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. The overall decrease in the rate since 2001 possibly reflects an increase in community-based specialised addiction services during this period. The increased rate in 2005 may be accounted for by the use of the 2002 census figure in calculating the rate. The decrease to 5.9 in 2006 reflects the new census figure used as denominator. Of the 659 discharges with a drug disorder, just under 48% spent less than one week in hospital and just over 17% spent more than one month in hospital.

(Jean Long)

1. Daly A, Walsh D and Moran R (2007) *Activities of Irish psychiatric units and hospitals 2006*. Dublin: Health Research Board.
2. Daly A, Walsh D, Ward M and Moran R (2006) *Activities of Irish psychiatric units and hospitals 2005*. Dublin: Health Research Board.
3. Daly A, Walsh D, Comish J, Kartalova-O'Doherty Y, Moran R and O'Reilly A (2005) *Activities of Irish psychiatric units and hospitals 2004*. Dublin: Health Research Board.
4. Daly A, Walsh D, Moran R and Kartalova-O'Doherty Y (2004) *Activities of Irish psychiatric services 2003*. Dublin: Health Research Board.
5. Walsh D and Daly A (2004) *Mental illness in Ireland 1750–2002: reflections on the rise and fall of institutional care*. Dublin: Health Research Board.

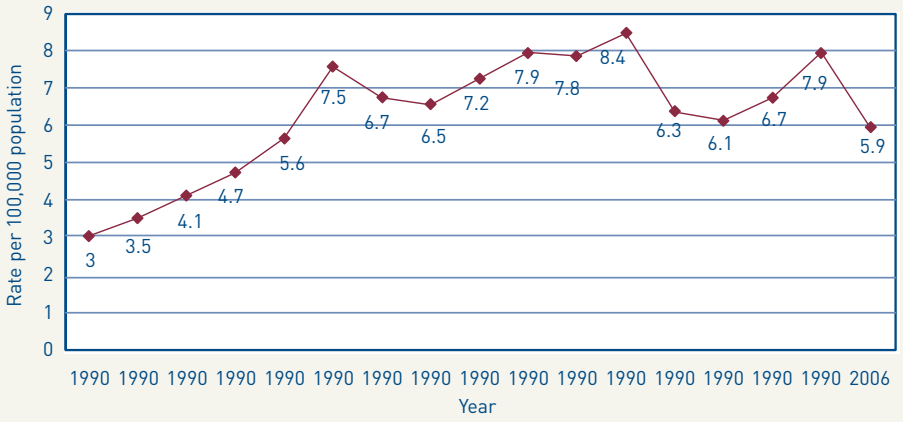

Figure 2 **Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the National Psychiatric Inpatient Reporting System, 1990 to 2006**

EMCDDA review of literature on cocaine treatments

Problem cocaine use is now the third most common reason for presenting for drug treatment in Europe. In light of this, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has published a summary of research into the treatment of cocaine dependency from a European perspective.[1] The main conclusions are highlighted here.

Psychosocial therapy is the mainstay of treatment for problem cocaine use but, despite lack of evidence, pharmacological treatment is also often used. However, there are some promising new pharmacological treatments such as topiramate (an anti-epileptic) and vaccination.

Psychosocial treatments, such as contingency management, have shown promising results in American studies. Residential treatment has shown no greater benefit than outpatient treatment. In general, the success rate of treatment for cocaine use is considered much lower than that for opioid dependence.

Polysubstance use is now a serious issue and appears to negatively affect treatment outcomes. Linked to this, there is evidence that crack cocaine users require different treatment to cocaine powder users. Therefore, specific treatment strategies, including harm reduction measures, need to be developed for these groups. Also highlighted was the need for intra-European studies to examine differences in crack cocaine use at local and national levels.

The majority of studies come from the US and, although these are useful, there is a need to conduct further research on treatments for cocaine users in a European context.

(Suzi Lyons)

1. EMCDDA (2007) *Treatment of problem cocaine use: a review of the literature*. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

European Legal Database on Drugs

The European Legal Database on Drugs (ELDD) was launched by the European Monitoring Centre for Drugs and Drug Addiction in 2001, and is now recognised as the definitive source of information on European drug laws.[1]

The database holds four types of information:

- *Legal texts* containing over 800 texts, usually in the original language but often with English translations.
- *Country profiles* outlining the legal aspects of the substances controlled and the main provisions of the various drug laws in all EU members states and Norway.
- *Topic overviews* of 'hot topics', such as the laws and penalties in relation to cannabis, drug classification systems, and treatment alternatives to prosecution or prison. Recent additions include the legal status of drug testing at work, hallucinogenic mushrooms, needle and syringe programmes, driving after taking drugs, controlled deliveries and precursor trafficking penalties.
- *Legal reports* providing more detailed, comparative analyses of the situation across Europe. For instance, the Substances and Classifications table lists 500 substances and their classification under national and international legislation. Also included are reports on drug substitution treatment, decriminalisation, the legal aspects of medical cannabis, drugs and young people, and the role of the quantity in the prosecution of drug offences.

These resources are supplemented by a News service, which provides an email alert to registered users (general public) informing them of newsworthy changes to member states' national laws or to EU laws or policies.[2] Visitors to the site can avail of this service by completing a registration form online. A network of legal correspondents, appointed by the governments of the member states, provide the ELDD with updates on national legislation. The Irish legal correspondent is based in the Alcohol and Drug Research Unit of the HRB.

Forthcoming activities of the ELDD include completion of a study on the emergency scheduling of new drugs throughout the EU and Norway and of another study on existing EU-wide administrative or non-criminal punishments for drug offences.

A number of significant legal provisions have been introduced into Irish law over the past two years.[3] In October 2006, provisions of the Criminal Justice Act 2006 for the registration of convicted drug offenders with the Garda Síochána were introduced. These provisions apply specifically to individuals convicted of drug trafficking offences and sentenced to a term of imprisonment of not less than one year. The Drug Offenders Register is based on the same principle as the Sex Offenders Register and will enable the movement of convicted drug dealers to be recorded in a similar manner; for instance, information relating to a change of address, or movement in or out of the country, must be supplied to the gardaí.

Parts 11 and 13 of the Criminal Justice Act 2006 relating to anti-social behaviour orders (ASBOs) came into force on 1 January 2007 for adults and on 1 March for children (aged 12–18 years). ASBOs are measures introduced to tackle anti-social behaviour such as intimidation, abusive or threatening behaviour and vandalism, some of which may be alcohol- and/or drug-related.

In May 2007, a number of new provisions contained in the Prisons Act 2007 came into force. Section 35 allows the Minister for Justice to make rules for the regulation and good government of prisons. Such rules may provide for the testing of prisoners for intoxicants, including alcohol and other drugs. Section 36 prohibits the unauthorised possession or use of a mobile phone by a prisoner, and the unauthorised supply of a mobile phone to a prisoner. There is anecdotal evidence that mobile phones have been instrumental in facilitating drug supply to prisons.

The Criminal Justice Act 2007 contains a number of important changes to the criminal justice system, including increased Garda detention powers, changes to existing provisions in relation to the right to silence, and the introduction of mandatory sentencing for a range of offences.[4] Many of these changes have been introduced in the context of growing concern about drug-related crime.

(Johnny Connolly)

1. http://eldd.emcdda.europa.eu/
2. http://eldd.emcdda.europa.eu/?nnodeid=5176
3. For further details on these provisions, see Alcohol and Drug Research Unit (2007) *2007 National Report (2006 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues*. Dublin: Health Research Board. An online copy can be found at http://www.ndc.hrb.ie/
4. See Connolly J and Morgan A (2007) The Criminal Justice Act 2007. *Drugnet Ireland*, Issue 22: 10.

Horizontal Working Party on Drugs – responding to street-level drug markets

The Horizontal Working Party on Drugs (HDG), a working group of the Council of the European Union, convened in December 2007 during the Portuguese presidency to discuss measures to curb the distribution of drugs at street level.[1]

Street-level drug markets and related crime and nuisance have been the focus of increased attention in recent years. Organisations such as the International Narcotics Control Board,[2] the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)[3] and the Pompidou Group of the Council of Europe[4] have highlighted the importance of this issue. In addressing the HDG, the EMCDDA points to the limitations of reliable data in this area. The EMCDDA is currently developing a project to improve local reporting of street-level drug distribution.

Presentations from Portugal, the UK, Cyprus and Ireland gave an indication of the diversity of strategies employed by EU states to tackle open drug markets. However, a theme common to all presentations was the importance of effective partnerships between law enforcement, other statutory agencies and local communities.

The Portuguese delegates emphasised the importance of partnership between policing authorities and local populations for the purpose of effective intelligence and information gathering. They identified continuous monitoring of drug use and availability in local populations as a priority. In their presentation on a community policing project launched in 2003, the Cypriot delegation, also considered the importance of co-operation between law enforcement and the community. In that project, community police provide reassurance at local level by means of house-to-house calls, public lectures, visits to key areas and attendance at events within the community.

A recent UK initiative involved a concentrated drive to disrupt drug markets, employing supply-reduction methods within a multi-agency framework. The UK delegation reported that this initiative led to a decrease in acquisitive crime, a disruption of local drug markets and increased insight into how such markets operated. Focused legislation in place since 2003 has facilitated the rapid closure of over 1,000 premises used in connection with the sale and distribution of Class A drugs ('crack houses' in particular). Similarly to the other presenters, the UK delegates emphasised the importance of communication and partnership between the local population and law enforcement authorities.

The Irish delegation provided an overview of recent local policing initiatives in the context of the establishment of pilot Joint Policing Committees (JPCs) under the provisions of the Garda Síochána Act 2005. These JPCs are to be established in 114 local authority areas throughout the state. Their primary functions are to serve as a forum for consultation, discussion and recommendations on local policing matters and to keep under review levels of crime, disorder and anti-social behaviour, including the patterns and levels of misuse of alcohol and drugs. JPC members will be drawn from local authorities, gardaí, public representatives and representatives from the community and voluntary sector. Furthermore, Section 36 of the Garda Síochána Act, 2005 provides for the establishment of local policing fora by a JPC. In light of Action 11 of the National Drugs Strategy, priority will be given to establishing such fora in all local drugs task force areas and other areas experiencing problems of drug misuse. At present, the Department of Justice, Equality and Law reform is co-ordinating a process of drawing up guidelines for these local policing fora.

The HDG concluded that the sharing of information about best practice in this area was crucial in developing an EU-wide approach. It also highlighted the ongoing work of groups such as the Pompidou Group's EXASS Net (European network of partnerships between stakeholders at frontline level responding to drug problems providing experience and assistance for inter-sectoral co-operation),[5] the European Forum for Urban Safety[6] and the European Crime Prevention Network.[7]

(Johnny Connolly and Anne Marie Donovan)

1. Horizontal Working Party on Drugs (2008) *Conclusions on the thematic debate – preventing the distribution of drugs at street level*. Cordrogue 14 SAN 14. Brussels: Council of the European Union.
2. International Narcotics Control Board (INCB) (2004) *Report 2003*. New York: United Nations Publications.
3. EMCDDA (2005) *Annual Report 2005: Selected issues*. Luxembourg: Office for Official Publications of the European Communities.
4. Connolly J (2006) *Responding to open drug scenes and drug-related crime and public nuisance – towards a partnership approach*. Strasbourg: Pompidou Group, Council of Europe.
5. http://www.exass.net/forum/login.php
6. http://www.fesu.org/
7. http://www.eucpn.org/

Report highlights limitations in Forensic Science Laboratory resources

A review of the Forensic Science Laboratory (FSL) by Professor Ingvar Kopp, former director of the Swedish National Forensic Science Laboratory and founding member of the European Network of Forensic Science Institutes, has found that approximately one-third of drug samples submitted by the Garda Síochána for analysis between 2000 and 2006 were not processed because of resource limitations.[1] As a consequence of this unmet demand for forensic services, he concludes, 'the detection and prosecution of crime is weakened … particularly so in drug analysis cases, where a certificate is required for prosecution' (p. 19).

Suspected drugs seized by the gardaí and by customs are submitted to the FSL for analysis to determine whether an illicit substance is present. Samples are submitted in tamper-evident bags, with a Garda form which lists the items being submitted. The Kopp report points to unnecessary bureaucratic obstacles, stating that 'in relation to drug cases, there is a lot of manual handling and duplication of data entry' (p. 16). The process by which items are received is, according to the report, 'very cumbersome', due in part to legal constraints and in part 'to practices grown with the development of the Laboratory' (p. 16). A time-consuming practice has developed whereby labels on the packing and detailed descriptions of the contents form part of the laboratory report. The report recommends that this practice be rationalised by means of FSL/Garda review of case management procedures and by the automation of procedures and minimisation of manual data entry.

The report also notes, however, that legal constraints require rigorous procedures to be in place. It is not unusual, according to the report, 'for the questioning in court to focus more on the physical appearance of the item rather than analytical results' (p. 16). This can occur even in drug cases, as the court may want to probe 'what the Garda recorded or saw prior to submitting the sample to the Laboratory' (p. 16). Furthermore, beyond the focus on the appearance of evidence, 'enormous and disproportionate demands' are placed on the laboratory arising from the need to certify the chain of evidence. The report recommends that the Law Reform Commission or another suitable expert body be commissioned to conduct a study in order to 'evaluate the scope for a more efficient means of approaching the management of physical evidence' (p. 17).

Table 1 shows the number of drug cases received by the FSL from the Garda Síochána and the number of cases reported (i.e. processed). Of the 61,639 drug cases submitted for analysis between 2000 and 2006, 41,230 were analysed, leaving a shortfall of 20,409, or just over 33%.

In addition to the unmet demands for the existing services available from the laboratory, the report points to the need for resources to cover an additional service, in the context of drug-related sexual assaults. The FSL has carried out alcohol determinations on biological samples submitted relating to victims of sexual assault. In more recent years, requests have been expanded to test for the presence of controlled drugs. However, the report points out that the FSL has not been able to meet this demand and estimates that, were it able to provide such a service, approximately 150 of such cases would arise annually.

The report also emphasises the importance of the FSL engaging with academic and research institutions, and recommends that the Department of Justice, Equality and Law Reform fund and support the FSL so that it can participate in joint research projects with other institutions, such as the Health Research Board (p. 41). In relation to drug purity, for example, this approach could enhance our understanding of the operation of illicit drug markets. Systematic purity testing of drugs seized at all market levels can provide useful information on market dynamics and profit margins.[2] Forensic analysis of seized drugs can also provide us with information on the types of dilutants used to bulk up drugs for street sale, a practice which can have important health consequences for drug users.

Although the FSL sometimes conducts ad hoc studies, only a very small proportion of drugs seized are tested to ascertain their percentage purity. For example, in 2003, the laboratory received over 600 suspected heroin cases, of which 11 were analysed to determine their percentage purity.[2] Further research such as that recommended in this report would assist in providing an evidence-base upon which to develop criminal justice interventions.

The study concluded that the current resource limitations have implications for crime control and law enforcement:

> The consequences of the current inability to meet actual and suppressed demands are serious. Investigations and prosecutions which could benefit from forensic analysis are deprived of additional insight and this has inevitable consequences in the fight against crime. (p. 8)

(Johnny Connolly)

1. Kopp I (2007) *Review of resource needs in the Forensic Science Laboratory and the wider scientific context in Ireland*. Dublin: Department of Health and Children.
2. Connolly J (2005) *The illicit drug market in Ireland*. Overview 2. Dublin: Health Research Board.

Table 1 Number of drug cases received and reported by the Forensic Science Laboratory 2000–2006

	2000	2001	2002	2003	2004	2005	2006	Total
Cases received	8658	10715	8673	8470	8192	8079	8852	**61639**
Cases reported	5111	5813	4764	5653	6251	6390	7248	**41230**
Shortfall	3547	4902	3909	2817	1941	1689	1604	**20409**

Source: Kopp (2007)

Addressing crime and anti-social behaviour in Limerick

The Fitzgerald Report recently submitted to the Cabinet Committee on Social Inclusion addresses social exclusion, crime and disorder issues in the Moyross and Southill communities and other disadvantaged areas in Limerick city.[1] The report advocates a strategic response which includes:

- interventions to address the issue of serious criminality;
- economic and infrastructural regeneration;
- Co-ordination between local authorities, gardaí and community and voluntary sector agencies to tackle entrenched disadvantage.

The report provides evidence from a variety of sources which highlights the decreasing quality of life in these communities. In particular, it points to statistics compiled by the Central Statistics Office indicating that these areas 'are among the most deprived in the country' (p. 5). Additional evidence collected by the author and his team indicates that members of these communities have suffered violent intimidation and damage to personal and council property from so-called 'criminal elements'. Other concerns include the number of young people involved in anti-social behaviour and drug distribution.

The report emphasises that economic and social regeneration cannot happen without 'intensive policing arrangements' (p. 8). It states that 'dealing with the serious (although relatively small in number) criminal elements … will be fundamental to creating the conditions for real progress to be achieved on all other fronts' (p. 6). This policing initiative will occur in the context of a five-year programme, the objective of which is to 'normalise and stabilise these areas' (p. 8). Specific recommendations include:

- targeting the assets of criminals by establishing a local CAB operation;
- maintaining a highly visible Garda presence in the area, which would involve dedicating up to 100 gardaí to these communities to restore public order and deal with criminal activity;
- empowering Limerick City Council to evict tenants involved in criminal or anti-social behaviour.

It is proposed that two new geographically defined development agencies (Limerick Southside and Limerick Northside) be established to co-ordinate the delivery of economic and social regeneration. With these structures in place, the report recommends a number of economic and social initiatives to address disadvantage, including:

- the attraction of commercial investment into these communities via fiscal incentive schemes;
- the development of transport infrastructure and access to these communities;
- the total regeneration of housing stock in these estates, including a mix of social and private housing.

It is recommended that special teams be established to co-ordinate the efforts of existing bodies to provide intensive and targeted interventions to local residents and families. These teams will be multi-disciplinary and are to include educational welfare officers, family support workers, local drugs taskforce and HSE representatives and community gardaí. Particular emphasis is to be place on the provision of activities and amenities for young people in the evenings and summer holidays.

In terms of drug abuse, Limerick city currently falls within the remit of the Mid-Western Regional Drugs Task Force. However, the report recommends that Limerick city benefit from local intervention initiatives, given that 'the problems of drug abuse in Limerick city are particularly acute' (p. 12). These interventions should also include prevention and education initiatives.

(Anne Marie Donovan and Johnny Connolly)

1. Fitzgerald J (2007) *Addressing issues of social exclusion in Moyross and other disadvantaged areas of Limerick City: report to the Cabinet Committee on Social Inclusion*. Dublin: Department of Community, Rural and Gaeltacht Affairs.

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Data collection and recording of deaths that lead to a coroner's inquest

The Central Statistics Office (CSO) is responsible for classifying the cause of all deaths in Ireland. In 1968 a statistical return (Form 104) was introduced 'to supplement the information on the Coroner's Certificate for the better statistical classification of cause of death'. The form was expanded in 1998 to facilitate a more detailed recording of the circumstances surrounding unexpected deaths, and now contains a number of mandatory fields: socio-demographic information, medical history, psychosocial factors, circumstances of death and contributing factors.

Deaths that lead to a coroner's inquest generally involve a chain of notifications and information transfers. The Garda Síochána are bound to report to the coroner any death that is unexpected, the result of an accident or suicide, or occurs in suspicious circumstances. Following an inquest, the coroner's certificate recording the verdict is forwarded to the Registrar of Births, Deaths and Marriages. The Registrar records the death on a death registration form (Form 102) and sends this form and the coroner's certificate to the CSO. The CSO uses this information to partially complete Form 104, which is then sent to the notifying Garda. The Garda completes the form, including a statement of his/her opinion as to whether the death was accidental, suicidal, homicidal or undetermined, and returns it to the CSO. Staff at the CSO determine the classification of the cause of death using the coroner's certificate, the death registration form (Form 102) and the statistical return (Form 104).

A report by the National Suicide Research Foundation presents the results of a study analysing data routinely collected in 2002 by means of Form 104.[1] A specific objective was to evaluate the usefulness of this form for collecting routine data on deaths, particularly suicides, that led to an inquest.

In 2002, 1,815 deaths required an inquest, of which 6% were not registered on time and were not included in the official statistics for that year, resulting in an underestimation of the number and causes of death. Almost half (48%) of the inquests took place within six months of death. Fifteen per cent were performed more than a year after death, of which 9%–15% were in provinces outside Dublin, and 27% were within Dublin. Over a quarter (26.5%) of inquests in which the cause of death was undetermined took place more than 12 months after death, compared to 8% of inquests that resulted in a verdict of suicide.

A Form 104 was completed for 1,718 (95%) of all the deaths in 2002 that led to an inquest. These forms had a high level of completeness for socio-demographic information (75% and above) but low levels for medical history and contributing factors (35% and below). In 88% of cases, Garda opinion as to the cause of death (as recorded on Form 104) agreed with that of the CSO.

The majority of unreturned forms related to deaths registered in Dublin. This may have led to inaccurate recording of the external causes of deaths in the area. Furthermore, the authors suggest that cases of suicide in Dublin were commonly misclassified as being of 'undetermined intent', which may partially explain the lower suicide rate found in Dublin compared to other areas of the country.

The most important findings were:

- The highest suicide rates occurred on Mondays, and in the months of April, May and June.
- The suicide rate for men (20.5 per 100,000) was higher then that for women (5.1).[2]
- The suicide rate for unemployed men (88.8 per 100,000) was higher than that for employed men (23.9).
- In general, a higher proportion of male deaths than female deaths were alcohol dependent.
- Fifteen per cent of suicide deaths were alcohol dependent, compared to one-fifth of deaths by accident, homicide or undetermined cause.
- One-third of undetermined deaths were drug dependent, compared to 13% of accidental deaths.
- Of the homicide deaths, one-quarter of the men were drug dependent, compared to none of the women.
- Of the suicide deaths, 34% of women were drug dependent, compared to 16% of men, and a higher percentage of women than men were dependent on prescription medication.

Although Form 104 has increased the range of information that can be collected at the time of death, it has some limitations, notably in that it does not have a 'natural death' option. This has resulted in submission by Garda members of incomplete forms or separate additional handwritten explanations. During the study period, all records were paper-based and liable to contain transcribing errors, which added to the inconsistencies in the data collected. However, the information is now recorded electronically, which the authors state should lead to a decrease in data-entry errors.

The authors make a number of recommendations:

- A new system should be developed to record medical and psycho-social information on deaths that lead to an inquest.
- Form 104 should be improved where possible but remain in use until a suitable alternative is developed.
- A clear written protocol should be provided to the gardaí nationally, to standardise information recorded on Form 104, especially for classification of suicides.
- Unnecessary delays in holding inquests should be identified and improvements made where necessary to reduce distress for the bereaved family and improve the timeliness of routine mortality statistics.

(Suzi Lyons and Simone Walsh)

1. National Suicide Research Foundation (2007) *Inquested deaths in Ireland: a study of routine data and recording procedures*. Cork: National Suicide Research Foundation.
2. Based on population data from the 2002 National Census.

EU Civil Society Forum on Drugs

The first meeting of the EU Civil Society Forum on Drugs was held in Brussels on 13 and 14 December 2007. Two Irish groups were among the 26 networks from EU member states selected to participate in the Forum – the Drug Policy Action Group and CityWide Drugs Crisis Campaign. Participation is for a two-year period, at the end of which there will once again be an open call for participants.

The establishment of this Forum is an important development in that it demonstrates the EU's willingness to accept that drug issues warrant discussion and that much of the expertise lies in the community. However, the EU recognises its limited powers in these matters, except in the areas of border control and policing, which raises questions about how much real impact the EU Drugs Strategy can have within individual member states.

The meeting had three main themes: (1) the Drugs Prevention and Information Programme; (2) drugs and prisons; (3) the EU Action Plan on Drugs. Participants initially met as a plenary group but then broke into two parallel working groups to discuss themes 2 and 3.

The Drugs Prevention and Information Programme (2007–2012)
This programme was presented to participants as a potential funding opportunity. As part of the programme, there will be a call in early 2008 for proposals for grant funding from organisations in all EU member states under various themes, including the creation of multidisciplinary networks, drug prevention and harm reduction, civil society involvement, and monitoring and evaluation of specific actions under the Action Plans 2005–2008 and 2008–2012.[1]

Drugs and prisons
EU work to date in relation to this matter was presented to participants. An external contractor was employed in 2006 to report on prevention, treatment and harm reduction services for people in prison, reintegration services upon release, and current approaches to monitoring and analysis of drug use among prisoners. This report was due to be finalised towards the end of 2007.

The Working Group on Drugs and Prisons was asked to 'discuss and report on common views for the preparation of the future proposal for a Council recommendation on drugs and prison', bearing in mind the presentation they had just heard and their own experiences. The issues raised included: equivalency of care issues, access to and the structure of treatment in prison, discharge plans and civil/human rights violations of prisoners in general, but especially of drug-using prisoners.

EU Action Plan on Drugs
The objective of the Working Group on the EU Action Plan on Drugs was to provide insights from civil society relevant to the evaluation of the Action Plan on Drugs 2005–2008 and, crucially, to the development of the Action Plan on Drugs 2009–2012. Issues raised included: polydrug use and the need for a wide range of treatment interventions, the needs of mobile drug users and of under-18s, and the need for a glossary of terms and definitions to accompany EU documents on drug issues.

The Action Plan 2009–2012 will be developed within the framework of the EU Drugs Strategy 2005–2012. Members of civil society can contribute to this process by sending written submissions on these points to the Commission.[2] It was emphasised that submissions should be 'realistic' and 'to the point' and that the Commission would decide 'how' and 'when' contributions would be used.

Reflections

- Some aspects of the organisation of the Forum ran contrary to the spirit of civil society engagement:
  - Details about the location and timing of the event were sent to members very late in the process. This meant that a number of networks, including DrugScope UK and the International Harm Reduction Association (IHRA), were unable to attend. This limited the scope and the quality of debate and feedback.
  - Documentation (including the agenda) was not received in advance of the event, so that participants were unaware of what issues to prepare for and were unable to consult with their membership.
  - Participants were presented with a large folder of documents upon arrival and had little time to read them and respond comprehensively and, again, had no opportunity to consult members.
- The Commission exerts very strong control in relation to the use of contributions and submissions.
- Participants were asked to leave ideologies 'outside the room'. This proved very difficult for some participants and made some discussions difficult.

Next steps

In the light of the problems outlined above and the fact that the new Action Plan will be developed during March/April 2008, it was suggested that the Forum meet again in Spring, allowing participants time to consult with their members and provide valuable feedback and recommendations.

The Commission did acknowledge and apologise for the manner in which the event was organised and the delay in sending documentation, promising to do better in the future. They agreed to send a full list of Forum participants and a summary report to all who attended; they also agreed to explore the possibility of having a meeting in Spring 2008. As yet, there has been no feedback on these matters.

However, despite the difficulties outlined, there is still value in engaging in this process for the following reasons:

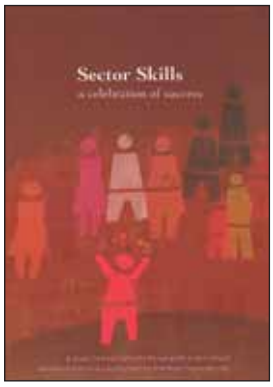
- It provides an opportunity to influence the new Action Plan on Drugs 2009–2012.
- Although the EU Drugs Strategy and Action Plans have no legal basis, recommendations made in such documents can be used as leverage in negotiations and can guide best practice.
- It is an opportunity to network, to learn and to influence other Forum members and the Commission, specifically the Anti-drugs Policy Co-ordination Unit.

(Niamh Randall, with thanks to Anna Quigley from CityWide)

Niamh Randall is Policy and Communications Officer with Merchants Quay Ireland and co-ordinator of the Drug Policy Action Group (www.drugpolicy.ie)

1. Application forms and guidance notes are available on the website: http://ec.europa.eu/justice_home/funding
2. For further information email JLS-DRUGS-PROGRAMME@ec.europa.eu

Sector skills: training for the non-profit sector



The Wheel is a support and representative body connecting community and voluntary organisations across Ireland. In 2004, the organisation initiated research into the training needs of this sector. This culminated in the development of a three-tiered pilot programme, called Sector Skills, designed to address priority training needs:

- **Training Links** – a training networking programme designed to provide an organisation-led approach to training and development in the non-profit sector, and to promote and support the development of training networks.
- **Stronger Leaders** – a leadership development programme, tailored for leaders of non-profit, community and voluntary organisations.
- **Learningpoint.ie** – a training opportunities website providing a single source of accurate, up-to-date information about training opportunities throughout the community and voluntary sector in Ireland.

The pilot phase for the Sector Skills initiative, which was part-funded by the Department of Enterprise, Trade and Employment,[1] ran from August 2005 to July 2007. An evaluation report of this phase was launched by Minister Billy Kelleher in December 2007.[2]

Deirdre Garvey, CEO of The Wheel, congratulated everyone who took part in the programme. She also welcomed the positive feedback from the evaluators; who examined all aspects of the programme, identified strengths and weaknesses, and made recommendations for the future.

(Mary Dunne)

1. The National Training Fund provided 80% of the costs and The Wheel sourced the remaining 20%. The Department of Community, Rural and Gaeltacht Affairs funded 10% of the costs of the www.learningpoint.ie website.
2. Coughlan C and Corrigan Matthews B (2007) *Sector skills programme: final evaluation report*. Dublin: The Wheel. www.wheel.ie/user/sector_skills/sector_skills_evaluation_report

Health Protection Surveillance Centre annual report 2006

The Health Protection Surveillance Centre (HPSC) annual report was published in December 2007.[1] The centre collates data on cases of infectious diseases, including those that are notifiable. Three infections are of particular importance in injecting drug users – HIV, hepatitis B and hepatitis C. The number of HIV cases and their characteristics were reported in a previous issue of *Drugnet Ireland*.[2]

Table 1 Numbers of hepatitis C cases notified to the Health Protection Surveillance Centre, 2004 to 2006

Year	Number of cases notified
2004	1131
2005	1434
2006	1226

Hepatitis C became a notifiable disease in 2004. In recent years, hepatitis C was primarily transmitted in Ireland through sharing equipment used to prepare and inject illicit drugs. The numbers of cases notified each year between 2004 and 2006 are reasonably high (Table 1). Seventy-five per cent of cases were reported by HSE services in Dublin, Kildare and Wicklow. Sixty-four per cent of cases were male and 71% were aged between 25 and 44 years. Risk factor data were not available for the cases recorded in these years, but the profile of cases corresponds with that of injecting drug users. The HPSC will collect risk factor data from 2007 onwards.

Hepatitis B is a vaccine-preventable disease which is transmitted through contact with blood or body fluids of an infected person. The main routes of transmission are mother-to-baby, child-to-child, sexual contact and unsafe injections. The number of cases notified to the HPSC increased each year between 1996 and 2005, and decreased by 8% in 2006. There were 820 cases in 2006, of whom 668 had a chronic infection, 93 had an acute infection and the disease status of 59 cases was unknown. Risk factor data have been reported since 2004 but the number of cases for which they are reported is very low. There is little specific data about hepatitis B among injecting drug users.

(Jean Long)

1. Health Protection Surveillance Centre (2007) *Annual Report 2006*. Dublin: Health Service Executive.
2. Long J (Autumn 2007) New data on the incidence of HIV. *Drugnet Ireland*. Issue 23: 15.

Ninth annual Service of Commemoration and Hope

Most Reverend Eamonn Walsh DD speaking at the service (Photo: JJ Berkeley)

On Friday 1 February, the Family Support Network held its ninth annual Service of Commemoration and Hope, entitled 'New Beginnings', in remembrance of those who have died from drug use and related causes. The service in Our Lady of Lourdes Church, Sean McDermott Street, was attended by Minister Pat Carey TD, a representative of the Taoiseach, the Lord Mayor of Dublin, Bishop Eamon Walsh and other religious representatives, as well family members, friends and representatives from family support groups throughout the island of Ireland and many people working in this area. The Minister, Bishop Walsh and Fr Edmond Grace spoke to the packed church, and prayers and poems were read, accompanied by music provided by the Dublin West Community Church Music Group.

The Family Support Network was announced as an independent organisation in November 2007. Formed in 2000 under the auspices of the CityWide Drugs Crisis Campaign, the Network consists of representatives of family support groups, individual family members and those working directly with families of drug users. It aims to raise awareness of family support work and its role in the community; highlight the importance and value of work done by family support groups; provide information to families and communities on existing services and supports; highlight the extent of the drugs problem and its effects on families; campaign for better services for drug users and their families; support the involvement of the people most affected – drug users and their families – in dealing with the problem; and remember and commemorate those who have died as a result of drugs.

(Suzi Lyons)

Contact the Family Support Network at 175 North Strand Road, Dublin 1. Tel: 01 8365168 or email: sadietgrace@gmail.com

Members of the congregation (Photo: JJ Berkeley)

The State Laboratory annual report 2006

Under its customer charter, the State Laboratory is committed to providing a top quality analytical and advisory service for all its customers in an efficient and effective manner.

The Human Toxicology Section of the Laboratory provides analytical support for criminal investigations and for coroners' investigations. The State Laboratory provides analysis on post-mortem biological samples to identify the presence or absence of legal drugs, illegal drugs and other substances and to quantify the levels of these substances. Information provided can indicate whether the deceased was taking medication or was under the influence of alcohol or drugs at the time of death, or whether a drug overdose was involved.

The main analyses carried out by the Human Toxicology Section in 2006 were ethanol determination, drug screening, drugs of abuse screening, quantification and determination of prescribed drugs and carbon monoxide determination. The screening for prescribed drugs can identify over 250 different drugs. Specific analyses are also available for illegal drugs, such as cocaine, ecstasy, opiates and cannabinoids. These drugs can be quantified and confirmed to a level that will satisfy the scrutiny of a court of law.

A total of 2,813 samples were analysed during 2006, an increase of 21.7% on the figure for 2000. Of these samples, 2,743 (97.5%) were analysed for coroners' cases and 70 (2.5%) were for analysed for criminal cases. Confirmatory analyses carried out included 1,318 opiate analyses, 411 amphetamine (including ecstasy) analyses, 481 cocaine analyses and 360 cannabinoid analyses. The most commonly found prescribed drugs were diazepam and metabolite (658 results), methadone (160 results) and paracetamol (146 results).

(Lorraine Coleman)

The State Laboratory website is at www.statelab.ie

1. The State Laboratory (2007) *Annual Report 2006*. Dublin: The State Laboratory.

Over-the-counter medicines – survey results

Landsdowne Market Research recently carried out a survey on behalf of Eireann Healthcare on public attitudes towards and knowledge about over-the-counter (OTC) medicines.[1] Five questions on the subject were put to a sample of 908 people:

1. Which, if any, of these complaints do you think aspirin helps: headache; toothache; stomach pain; heart disease; or other?
2. What is the youngest age at which it is advisable to give a child aspirin?
3. Should paracetamol tablets be taken during pregnancy?
4. Which of the following can only be treated by prescription medicine: eczema; ulcers; stomach complaints; period pain; thrush; migraine or diarrhoea?
5. If the medicine you needed for a minor illness was available without visiting a GP, would you be confident to take that option?

Results were categorised according to age, gender, marital status, social class and region. Key findings from the survey showed that:

- More than one in four people (26%) think aspirin helps stomach pain. Aspirin may in fact be potentially dangerous for people with stomach pain as it may be a symptom of ulcers, and aspirin can cause ulcers to perforate.
- Less than one-third of people surveyed know that OTC medication is available for thrush and would visit a GP for prescription medication rather than self-medicate.
- Almost half of respondents (45%) were unaware that OTC medication was available for eczema and would visit a GP for prescription medication.
- Almost half of respondents (48%) would give aspirin to children under 16.
- Only 34% of female respondents knew about the dangers of taking paracetamol during pregnancy.
- Eighty five per cent of people surveyed would be confident to receive OTC treatment for a minor illness from a pharmacist rather than a GP if the option was available.

(Lorraine Coleman)

1. Nalini Nathan of First Medical Communications provided an outline of the survey results for this article. www.firstmedical.ie

Father Joe Lucey RIP

The late Father Joe Lucey SDB spent over 15 years working and living in the community of Dublin's North East inner city. Based at the Crinan Youth Project in Seán McDermott Street, Fr Lucey worked with several organisations and was instrumental in the development of initiatives to benefit the local community.

He will be sadly missed by all who knew him.

Directory of training courses for 2008

The National Documentation Centre on Drug Use has published a new edition of the Directory of courses and training programmes on drug misuse in Ireland. Thirty-six providers sent us information about 94 courses for this third edition. We would like to thank all of those who made contributions.

The Directory lists a range of training available, from single sessions to courses lasting up to two years. A wide variety of training standards, methods and approaches are represented. We do not assess the quality of courses listed; we present information as supplied by the course co-ordinators on course length, assessment, qualifications and accreditation.

Most courses are targeted at a specific audience. In particular, a large number of courses and training programmes have been designed for workers in the area of drug misuse and for parents. Many are offered at both in-house and external locations. Some courses do not refer directly to drugs or addiction but aim to develop broad skills, such as supervision, facilitation and counselling techniques, which may be of interest to those working in this area.

Course providers are based in Dublin (61%), Cavan, Donegal, Kildare, Mayo, Meath, Tipperary, Waterford and Wexford. Although many cater specifically for people in their locality, some also offer courses on a regional or national basis.

(Mary Dunne)

Course co-ordinators who wish to revise an existing entry or include a new course in the 2009 edition of the Directory may request an application form from mdunne@hrb.ie

New Drugs Policy page on NDC website

While the Irish government is ultimately responsible for drug policy in Ireland, the content of that policy evolves through a complex process of research, analysis and ongoing debate. The National Documentation Centre (NDC) has collected the current suite of Irish drug-related policy documents, together with a record of Irish Parliamentary debates on the drugs issue and links to the wider network of international, national, regional and local bodies that contribute to thinking and debate on the issue in Ireland. This material is now available on a new Drugs Policy page on the NDC website.

This web page provides a framework for accessing the websites of the main bodies engaged in influencing the formulation of Ireland's policy on illicit drugs, be it through drug-related research, information exchange, debate on the issues, or policy development.

The bodies contributing to or influencing the formulation of Ireland's illicit drugs policy fall into six broad categories. Information on the most influential bodies in each category, and links to key policy documents produced by or associated with them, are available under each of these headings:

European Union institutions and agencies

International and European non-governmental organisations

Irish drugs policy and co-ordination

Irish non-governmental organisations

Other inter-governmental bodies

United Nations institutions and agencies

The Drugs Policy page can be accessed through the Drugs in Ireland page on the NDC website at www.hrb.ie/ndc.

From *Drugnet Europe*

Standardising the monitoring of drug-related public expenditure

Article by Luis Prieto, Drugnet Europe *No. 61, January–March 2008, p. 3.*

Producing estimates of drug-related public expenditure is one of the many targets set by the current EU drugs action plan (2005–2008). In this light, the EMCDDA is working to identify and test suitable monitoring tools with the aim of developing a common EU methodology for data-collection in this area. The ultimate goal is to quantify how much countries are spending on addressing the drug problem (e.g. healthcare, law enforcement, social services, drug policies). This will in turn provide policy-makers with the evidence-base they need when allocating resources to drug-related programmes and services.

The EMCDDA's strategy for developing such a common methodology received the support of an expert meeting held in Lisbon from 13–14 December, attended by 14 consultants from the areas of drug policy and economics. This methodology is based on a classification of expenditure divided into two types: 'labelled' and 'unlabelled'.

'Labelled expenditure' refers to planned spending, reflecting the voluntary commitment of the state in the drugs field, and can be traced by exhaustively reviewing official accountancy documents over a given period. However, estimates are often complicated when expenditure is embedded in programmes with broader goals (e.g. overall police operations budget). In such cases, 'unlabelled expenditure' is estimated through modelling techniques. It is hoped that this new, twofold approach will not only provide more comprehensive and accurate estimates of public spending in tackling drugs and drug addiction Europe-wide but also strengthen governments' commitment to budgetary transparency and accountability.

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and is available at www.emcdda.europa.eu.

If you would like a hard copy of the current or future issues, please contact:

Alcohol and Drug Research Unit
Health Research Board
Knockmaun House
42-47 Lower Mount Street
Dublin 2
Tel: 01 2345 127; Email: adru@hrb.ie

In brief

On 1 November 2007 the **Policing Priorities for An Garda Síochána for 2008** were announced by Brian Lenihan TD, Minister for Justice, Equality and Law Reform. A top priority, which the Garda Commissioner must take into account in preparing his policing plan for 2008, is gun crime, organised crime and drugs. The aims are:

- targeting through the use, in particular, of specialist units and targeted operations such as Operation Anvil;
- profiling, intelligence gathering and threat assessments in relation to individuals/ groups involved in these categories of crime;
- delivery on Garda actions and performances set out in the National Drugs Strategy;
- the pursuit by the Criminal Assets Bureau (CAB) of the proceeds of crime, including, through the presence of enhanced liaison arrangements between Garda divisions and CAB, the assets of those engaged at any level in drug dealing; and
- enhanced activities by the Drugs Units and the Force focusing, in particular, on places throughout the country where the presence of drug dealing and the use of illicit drugs is likely. www.garda.ie

On 15 November 2007 the ***Social Inclusion Report Ireland 2006–2007*** was launched. It reports on progress against the targets/actions contained in NAPinclusion 2007–2016, i.e. the National Action Plan for Social Inclusion. It lists the targets and progress for drug-related measures under Children and Communities. www.socialinclusion.ie

In November 2007 the ***Irish Prison Chaplains Annual Report 2006/07*** was submitted to the Minister for Justice. Overall, it argues for a shift from punitive to restorative justice. In respect of drugs, the report states: 'The misuse of drugs continues to be a major problem in most of our prisons. We welcome the introduction of drug counsellors and addiction nurses and we hope that their expertise in dealing with drug addiction will help address the drug culture that prevails. Given the ongoing debate around methadone maintenance, we hope this additional service will offer greater possibilities and opportunities to those struggling to remain drug free. We strongly recommend that resources be made available for those prisoners who plead for help in the whole area of drug addiction. To date, at any given time only nine prisoners may avail of a special six-week course in Mountjoy to address their addiction. Surely this must be seen to be insufficient when the drug addiction is the cause of so many prisoners been incarcerated in the first place. There are numerous prisoners who look for a drug free landing in order to stay away from drugs but they are few in number. Many people will in fact have been introduced to drugs initially while they were in prison. Sniffer dogs have been introduced in some prisons, which have reduced the quantity of drugs getting into the prison. This can cause tension on the landings when the supply is short. We call for a systematic approach to be implemented so that as the supply is diminished the appropriate support be offered in its place.' www.cfj.ie

On 5 December 2007 the **Drugs Initiative budget for 2008** was announced. The following day, Minister of State Pat Carey TD stated in Dáil Éireann: 'In respect of the area for which I am responsible, I welcome the €12.5 million increase in funding for drugs programmes in 2008, which the Minister for Finance announced in yesterday's budget. This increase of more than 25% constitutes a major funding boost for drugs programmes next year and builds on increases in funding secured for these programmes in the past three years. It reaffirms the high priority the Government continues to give to tackling the drugs problem. The 2008 allocation of €64 million, of which almost €56 million is current funding and €8 million is capital funding, will facilitate progress towards the fulfilment of drug-related commitments in the programme for Government.' www.oireachtas.ie

On 20 December 2007 the **Irish Prison Service** published its annual report for 2006. The document reports overall progress in relation to drug treatment and rehabilitation services and the elimination of the supply of drugs in prisons. It also includes reports in respect of each individual prison: statistics are given on methadone treatment in prisons, and the number of those in prison on drug offences, including a breakdown by age of offender and length of sentence. www.irishprisons.ie

In December 2007 the **Beckley Foundation** published its 14th report ***The effects of decriminalisation of drug use in Portugal***. The report states that the statistical indicators suggest that, since decriminalisation in July 2001, there has been increased use of cannabis, decreased use of heroin, increased uptake of treatment, and reduction in drug-related deaths. Decriminalisation has enabled earlier intervention and more targeted and therapeutic responses to drug users, increased collaboration across a network of services, and increased attention to adopting policies that work. This is perceived to be reducing the level of current and future drug use and harm. Yet, key informants also reported that impacts were less than expected and that there were concerns over the message that decriminalisation was sending to new drug users. www.idpc.ie

In January 2008 a research study ***Accident & Emergency Nursing Assessment of Deliberate Self Harm*** was released by the **HSE South** and the **National Suicide Research Foundation Ireland**. It reports on a pilot study exploring 'the impact of introducing a suicide education programme and a suicide intent scale into A&E/MAU nursing practice'. The study was based on the concern that inadequate assessment of deliberate self-harm (DSH) patients may result in failure to diagnose treatable underlying conditions such as alcohol dependence. Key findings of the study were that (a) the provision of training was associated with a significant increase in nurses' confidence in dealing with DSH patients and positive changes in their attitudes towards suicidal behaviour and its prevention, and (b) the use of a suicide intent scale is potentially valuable in referring DSH patients presenting at A&E/MAU to the appropriate service. www.nsrf.ie

On 3 March 2008 the stimulant **BZP (1-benzylpiperazine)** became subject to 'control measures and criminal provisions' across the EU member states, following a decision by the **European Council** (Document number 6573/08: Council Decision on defining 1-benzylpiperazine (BZP) as a new psychoactive substance which is to be made subject to control measures and criminal provisions). The Council decision was the final stage of a three-step procedure designed to respond to potentially threatening new psychoactive drugs in the EU. Ireland's Department of Health and Children has begun the process of declaring BZP to be a controlled substance under Irish Misuse of Drugs legislation; this process will be completed within one year. www.consilium.europa.eu

(Compiled by Brigid Pike)

Recent publications

Journal articles

The following abstracts are cited from recently published articles relating to the drugs situation in Ireland.

Illegal drug use, smoking and alcohol consumption in a low-risk Irish primigravid population

Donnelly JC, Cooley SM, Walsh TA, Sarkar R, Durnea U and Geary MP
Journal of Perinatal Medicine 2008; 36(1): 70–72

The aim of this research was to evaluate the prevalence of illegal drug use, smoking and alcohol consumption in Irish primigravidas. 1,011 women were interviewed at their booking visit. A total of 23.5% (235) of women had used illegal drugs prior to their first pregnancy, 28.9% were ex-smokers and 27.9% were still smoking during pregnancy. A total of 53.9% admitted to drinking alcohol during pregnancy. Smokers are 2.8 times more likely to have used drugs in the past than non-smokers. Level of alcohol consumption appears to be a significant predictor of drug use.

Listening to people with intellectual disabilities who misuse alcohol and drugs

Taggart L, McLaughlin D, Quinn B and McFarlane C
Health & Social Care in the community 2007; 15(4): 360–368

Very little research has explored alcohol/drug use and misuse by people with intellectual disabilities. The aims of the present study were twofold: (1) to examine the insights of 10 people with intellectual disabilities into the reasons why they may misuse alcohol or drugs, and what impact this behaviour may have on them; and (2) to explore the services that they receive. Ten individuals with intellectual disabilities who were deemed to be misusing alcohol/drugs were purposively selected and interviewed. One overarching theme of the reasons for such misuse was labelled as 'self-medicating against life's negative experiences'. This was divided into two sub-themes: 'psychological trauma' and 'social distance from the community'. All the participants reported that their main source of support came from intellectual disability services, acting in both educational and liaison roles. Although seven of the individuals were referred to mainstream addiction services, they perceived this service as negative. In order to address these underlying problems, better access to a wider range of specialist services is required. Intellectual disability and mainstream addiction service providers also need to be more effective in the prevention and treatment of substance misuse by employing techniques such as motivational interviewing.

Opiate dependence and pregnancy: 20-year follow-up study

Whitty M and O'Connor J
Psychiatric Bulletin 2007; 31: 450–453

This study examined the 20-year outcome of 55 women who were pregnant and using opiates in 1985 and were attending the Drug Treatment Centre Board in Dublin. We established outcome across a number of variables, including mortality, psychiatric and physical morbidity, psychosocial functioning, ongoing drug misuse and outcome of offspring. At 20-year follow-up 29 women (53%) were deceased; HIV accounted for 17 deaths (59%). Those who were alive at follow-up displayed high rates of unemployment (84%) and of illicit substance misuse (74%), and most were dependent on state-subsidised accommodation (78%). Mortality was higher in our group than in other long-term follow-up samples. These findings suggest that such participants and their offspring require intensive long-term support and treatment.

Influence on self-rated health of socio-demographic, lifestyle and affluence factors: an analysis of the Irish and International Health Behaviour among School-Aged Children (HBSC) datasets 1998

Kelleher CC, Tay J and Gabhainn SN
Irish Medical Journal 2007; 100(8): suppl. 43–46

In this analysis we employed the international Health Behaviour Among School Aged Children (HBSC) 1998 data, comprising 8,326 Irish children and 115,327 children in the international dataset, to examine influences on self-reported health among young people. Factors were similar for both boys and girls and between countries. Daily smokers, those reporting intoxication at least once, those taking infrequent exercise and those reporting difficulty in making friends were all predictive of poor self-rated health in adjusted odds ratio models. Disposable means, as measured by the Family Affluence Score was also a significant predictor of self-rated health but not as influential as reported lifestyle. In a multi-level, between-country comparison of 15 OECD countries, individual health behaviours explained much, but not all, of the variability in poor self-reported health (0.26, SE 0.08) and, of various ecological level indicators considered in the final model, only % voting and % males with minimum 2nd level of male education in the population were influential factors, with between-country variations still not fully explained (0.10, SE 0.03).

Poverty, health and participation

Cosgrove S
Irish Medical Journal 2007;100(8): suppl. 73–75

Poverty is an important influence on health and, despite continuing economic growth, poverty and health inequalities persist. Current public policy aims to reduce the inequalities in health by focusing on the social factors influencing health, improving access to health and personal social services for those who are poor or socially excluded and by improving the information and research base in respect of the health status and service access for the poor and socially excluded groups. It is important that processes for target setting and evaluation involve people experiencing poverty, at all levels, through consultative and participative structures and processes and in the roll-out of primary care teams. A number of projects throughout the country aim to address health inequalities using community development. These are essentially about widening participation in the development, planning and delivery of health services and ensuring that the community is actively involved in the decision making process about health services in their area.

(Compiled by Louise Farragher)

Upcoming events

(*Compiled by Louise Farragher* – lfarragher@hrb.ie)

May

7–15 May 2008
Cork Drug Awareness Week 2008
Organised by/Contact: Jacqueline Daly jdaly@partnershipcork.ie or Mella Magee mmagee@partnershipcork.ie
Tel: +353 (0)21 430 2310

Information: The aim of Cork Drug Awareness Week is to raise awareness and signpost information so that communities, families and professionals know where to go for assistance or information on drug and alcohol use. Events taking place include:

7–10 May 2008
Drug and Alcohol Workshops, Activities and Competitions for Youth Group members in out of School Settings
Venues and dates to be confirmed.

13 May 2008
Conference: Brief Interventions to Reduce Drug & Alcohol Related Harm: Who, Where and When?
Venue: Imperial Hotel, South Mall, Cork. (9.30am – 2.30pm)

Information: Targeted at professionals, concerned individuals, and community representatives. Includes the launch of a multi-lingual, locally produced leaflet Brief intervention on alcohol.

15 May 2008
Family Information Event
Venue: Clarion Hotel, Cork (7pm-10pm)

Information: Accessible information evening targeted at families and concerned people with an interest in or affected by drug and alcohol misuse.

11–15 May 2008
International Harm Reduction Association 19th International Conference: Towards a global approach
Venue: Palacio de Congresos, Fira de Barcelona, Spain
Organised by/Contact: International Harm Reduction Association (IHRA)
Tel: +44 (0) 207 462 6997
Fax: +44 (0) 207 462 6999
Email: info@ihraconferences.com
www.ihra.net/Barcelona/Home

Information: IHRA's harm reduction conferences have been held around the world every year since 1990, and the next event takes place in Barcelona. Over five days, this conference will be the main meeting point for those interested in harm reduction, and an invaluable platform for debate, discussion, and the dissemination of new and evolving good practice in addressing drug use and associated harm.

21–22 May 2008
Tabor Lodge Annual Seminar. Beyond Trauma: A healing Journey for Women
Venue: Carrigaline Court Hotel, Cork
Cost: €200
Organised by/Contact: Tabor Lodge
Tel: +353 (0)21 488 7110
Email: taborlodge@eircom.net

Information: Download the booking form from www.drugs.ie/pdf/TaborLodge.pdf

23 May 2008

Young People, Alcohol, and Drugs: A World of Solutions
Venue: O' Reilly Hall, University College Dublin
Organised by/Contact: Juvenile Mental Health Matters
Email: muriel.keegan@ucd.ie
www.juvenilementalhealthmatters.com

Information: This year's conference will launch a major research study on alcohol use, drug use and family functioning conducted in Ireland with 492 young people and will invite a team of international experts from the UK, the US, and Australia to respond on evidenced based approaches to working with young people who use and abuse alcohol and drugs. See JMHM website for full details.

29–31 May 2008
EUROPAD 8 Conference
Venue: Kempinski Hotel, Sofia, Bulgaria
Organised by/Contact: EUROPAD: European Opiate Addiction Treatment Association
www.europad.org

Information: Further details to be announced.

30 May 2008

Harm Reduction Conference: Meeting the Challenge
Venue: Village Hotel, Swansea
Organised by/Contact: Swansea Drugs Project, 8 Calvert Terrace, Swansea, SA1 6AR
Tel: +44 (0) 1792 472002
Fax: +44 (0) 1792) 472004

Information: Speakers include:

- Keynote Speaker: Patrick O'Hare, Geneva (International perspective and overview)
- Brian Gibbons, Welsh Assembly Government Minister
- Josie Smith, National Public Health Service (HIV / Hepatitis C)
- Neil Hunt (Injecting rooms)
- Julian Race (Diamorphine prescribing)
- Andrew Preston (Harm reduction / Exchange supplies)
- Tony Duffin, Ana Liffey Drug Project, Dublin (Low threshold – Harm reduction)
- Rob Llewelyn (Harm reduction and pregnancy)
- Michael Linnell, Lifeline (21 years of harm reduction information)
- Jayne Peters, Treatment Services Manager, Bristol Drugs Project
- Melanie Seddon (Alcohol and harm reduction)

The closing date for applications is 26 May and places are limited.

June

23–25 June 2008
Club Health 2008. The 5th International Conference on Nightlife, Substance Use and Related Health Issues
Venue: Santa Eulalia, Ibiza, Spain
Organised by/Contact: Club Health 2008, Centre for Public Health, Liverpool John Moores University, Castle House, North Street, Liverpool L3 2AY, UK
Tel: +44 (0)151 231 4384
Email: k.e.hughes@ljmu.ac.uk
www.clubhealth.org.uk

Upcoming events *(continued)*

Information: Club Health 2008 is the 5th International Conference on Substance Use, Nightlife and Related Health Issues and marks a decade of Club Health conferences. The event aims to promote the development of safer nightlife environments, and will provide an international forum for the exchange of experience, knowledge and practice on nightlife health and the management of night-time environments.

July

7–9 July 2008
Beyond 2008 Forum
Venue: Vienna, Austria
Organised by/Contact: Vienna NGO Committee
www.vngoc.org
info@vngoc.org

Information: Beyond 2008 is a joint initiative of the Vienna and New York NGO Committees on drugs to facilitate an effective contribution from NGOs to the UNGASS Review. The target date of 2008 agreed at the 1998 UNGASS on Drugs for the achievement of 'significant and measurable results' presents an opportunity for the NGO community to reflect on its own achievements in drug control, exchange ideas on promising new approaches, reach agreements on ways to work together and make recommendations to multilateral agencies and UN member states on future directions for drug control. Building on past experience, the Vienna NGO Committee will host Beyond 2008 to contribute to the 1998–2008 review and agenda-setting exercise being undertaken by the Commission on Narcotic Drugs (CND).

17–18 July 2008
Alcohol, Drugs and Criminal Justice Series: What about Harm Reduction?
Venue: Warwick University
Organised by/Contact: The Conference Consortium – in partnership with the NTA (National Treatment Agency), IHRA International Harm Reduction Association), DrugScope, Offender Health and Coventry and Warwick PCT.
Email: warwick@conferenceconsortium.org
www.conferenceconsortium.org

Information: This is the third event in the 'Alcohol, Drugs and Criminal Justice' series. This conference will be returning to Warwick University to discuss harm reduction, what it means, how it applies to different fields of work and how it can be practically implemented. This promises to be an important conference at an important time with the launch of the new UK Drug Strategy in 2008 and the ongoing implementation of the UK Alcohol Strategy.

This event will also report from 'Harm Reduction 2008', IHRA's 19th International Conference (Barcelona, May 2008) to highlight the key messages from the International Harm Reduction movement. The conference will focus on four different sectors and how they can, (and must) interact and work together to provide the best services: Arrests and the Courts; Prisons; Probation and aftercare; Alcohol and drug community treatment programmes.

October

12 October 2008
Addiction is a Choice
Venue: Herringham Hall, Regent's College, Inner Circle, London NW1
Organised by/Contact: Anthony Stadlen, 'Oakleigh', 2A Alexandra Ave, London N22 7XE
Tel: +44 (0) 20 8888 6857
E-mail: stadlen@aol.com
www.schaler.net

Information: Professor Jeffrey A Schaler is the world's leading disbeliever in 'addiction'. He is an existential psychotherapist and full-time professor at American University's School of Public Affairs in Washington DC. His book Addiction is a Choice (2000) argues that:

- No drug (including alcohol and tobacco) is 'addictive'.
- Drugs are not intrinsically safe or dangerous, good or bad.
- Disease refers to cellular pathology, not behaviour.
- 'Loss of control' is an unfalsifiable, hence unscientific, hypothesis.
- 'Addiction' is ethical, not medical.
- Focusing on the existential reasons for 'addiction' can help drug users address and resolve the problems in living they try to solve with drugs.

Whether you agree, disagree, or are undecided, you are welcome to discuss Professor Schaler's argument and evidence with him at this important seminar.

The Alcohol and Drug Research Unit (ADRU) of the Health Research Board is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug situation, its consequences and responses in Ireland.

The ADRU maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. The unit also manages the National Documentation Centre on Drug Use.

The ADRU disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland*, and other publications. Through its activities, the ADRU aims to inform policy and practice in relation to drug use.

***Drugnet Ireland* is published by:**
Alcohol and Drug Research Unit
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Knockmaun House
42–47 Lower Mount Street
Dublin 2
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